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## Clinical Lecture.

### THE TREATMENT OF TYPHOID FEVER IN CHILDREN *

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*Gentlemen* :—By a mere coincidence there have just been admitted to our wards, four children suffering from typhoid fever, and I will take the opportunity to study with you the treatment of this disease in children.

Our little patients present different types of the affection. I will here state that the treatment varies somewhat according to the forms of the malady, and that certain typhical conditions require especial management. I will refer to this point later, perhaps at the conclusion of the lecture. In the meantime, I will remark that the treatment of typhoid fever, in my opinion, is subject to certain rules, rules which I will present to you in a synthetical form. In the first place we will examine the forms of the disease in our patients, and then direct our attention to the line of treatment which we shall pursue in each one of them.

The first patient is a boy, 13 years of age, who entered the Hospital on the 15th day of the disease. Up to this time the disorder had followed a regular course, and the patient exhibited a marked eruption of rose-colored spots. According to certain authors these rose-colored spots appear on children with the same regularity as they do in adults, and that the eruption exhibits the same confluent form. Up to the 20th day everything went on regularly with our patient, but at this time there occurred a sudden change; the temperature was considerably lowered, and there appeared what may be called a true urinary crisis, the increased amount of urine being 1500 grammes in twenty-fours hours. In fact, the patient had entered into a condition of convalescence. On the following morning, however, that is on the 21st day of the disease, there came, entirely unforseen, an abundant intestinal hæmorrhage. Intestinal hæmorrhage in typhoid fever in children is of rare occurrence, it being due, I believe, to the fact that in these patients Peyer's patches are not generally hard, infiltrated with lymphatic elements, and that there are no sloughs produced which on being detached give rise to hæmorrhage. In children Peyer's patches are simply exulcerated. Although rare, as I have remarked, intestinal hæmorrhage may appear under two distinct conditions and offer a quite different diagnosis. In certain instances, as in this case, the hæmorrhage is unaccompanied by serious symptoms. The general condition of the child remains good, the frequency of the pulse is comparatively unimportant, and there is no marked elevation of the bodily temperature. Hæmorrhage constitutes, therefore, in these cases, a peculiar kind of crisis. I have seen many examples of this critical hæmorrhagic condition, but I can positively state that I have never observed any serious symptoms develop. On the other hand, when the hæmorrhage is threatening in an individual in whom the temperature is high, the pulse frequent, and in whom there is a general adynamic condition of the system, then hæmorrhage is extremely serious and is generally followed by death. In these cases the hæmorrhage is due to marked alteration of the blood, and may always be considered as a phenomenon of approaching dissolution.

In our patient the hæmorrhage occurred under the most favorable circumstances, and I, therefore, adopted the following treatment: Ice upon the abdomen; two enemata each containing four to five drops of laudanum, to be injected in the twenty-four hours; cooling lemonade drinks; a mixture containing 1 gramme of the tincture of the perchloride of iron. I also advised absolute rest and a diet of cold broths. As I had reason to expect, the results have been most

*Delivered at "Hospital des Enfants-Malades," Paris.

excellent. The convalescence of our young patient has been steady, and to-day (the 28th of the disease) he is doing as well as could be desired. The hæmorrhage stopped three days ago, and he has commenced to partake more or less of a nourishing alimentation. He will be advised to continue the perchloride of iron during the period of convalescence.

The point I wish to impress regarding this particular case is, that the occurrence of hæmorrhage should not be a cause of despair. If the general symptoms are favorable, you must not fear to push the treatment I have indicated, with a right to expect and obtain a happy issue.

The second patient to whom I wish to call your attention, exhibits a type of abortive typhoid fever, in which the symptoms ceased about the 15th day, notwithstanding that the disease is apparently ready to avert or produce at the same time serious troubles. The patient is nine years of age, and entered our service on the 18th day of the disease, with all the typical phenomena of a mild typhoid fever. In this, as in the majority of children, no prodromic symptoms were observed, notwithstanding that the period never fails to appear. This prodromic period, which we have never noticed in this Hospital, will be most frequently met with in your civil practice. In children, it is true, this period of typhoid fever presented phenomena characterized by symptoms of a generally mild nature. The patients show a peevish disposition, suffer from irregular attacks of headache, perhaps one or two during the day. There may be a slight reaction, of a short duration; and, finally, with the appearance of a capricious appetite, there may come on a change in the usual character of the patient. You must be careful, however, in studying the different signs in order to avoid errors; for while you may be assuring the parents of the child of the commencement of a typhoid fever, you may be really dealing with a simple catarrhal affection. Again, you may attribute the symptomatology to an approaching attack of abortive typhoid fever, especially if the general aspect of the patient is not in accord with the rest of the symptoms, particularly with the elevation of temperature. If the general condition of the child is good, and there is an increased bodily heat, the probability is that you are contending with an abortive form of the malady. Apropos of this, I will state that in children the temperature rises easily, sometimes going up as high as 40°C., under the influence of the slighest emotion. It behooves us, therefore, not to suspect the existence of typhoid fever simply on account of the high temperature. You have seen, it is true, in our patient an evening temperature of 40°C., appearing constantly for seven consecutive days, and, nevertheless, convalescence has been established; but at the same time, the pulse, which had been exceedingly frequent, has fallen to 90 *pari passu* with the disappearance of the other symptoms.

Our third patient shows another type of typhoid fever. Not only the usual symptoms have been developed in this case, but, besides, other symptoms of an ataxo-adynamic character have been manifest. In the presence of these nervous symptoms I have thought best to treat the case by the hydrotherapic method. The result of this treatment has been most favorable. At this time I have no longer insisted on the application of baths, although I have always formulated this treatment in general. The child is to-day in a good condition, and convalescence has been completely established.

Our fourth and last patient to-day, is a typical case of typhoid fever, without complications or any anomalous character. In cases like this I advise a general treatment of which I desire to speak to you, a treatment that I invariably employ in regular, uncomplicated cases of typhoid fever in children.

In the first place hygiene must be attended to. As soon as the correct diagnosis is made I order the patient to remove to a new habitation, and a change of bed clothing morning and night. At the same time I order bathing, evening and morning, of the whole body, with aromatized water (thymol or cologne) at a temperature of 30° C. If the bodily temperature is elevated, say to 40° C., I order this bathing to be applied with even more frequency if the heat of the body should show a tendency to increase. This bathing is to be made by means of a sponge, and rapidly, first over the anterior and then over the posterior part of the body, after which the patient should be rapidly wrapped up in order to obtain a slight reaction.

This sponge bathing, I repeat, I am in the habit of employing in every case, and I especially recommend it to be applied frequently in cases of high temperature, and only when there are manifest no serious phenomena of a nervous character. On the contrary, when symptoms of an ataxo-adynamic nature accompany the elevation of

the temperature, then I have recourse to the application of general cold, or better warm baths.

I will not to-day study from a general point of view the question of the employment of cold baths in the treatment of typhoid fever, nor especially how such a measure acts in the case of adults. I will confine my remarks to the consideration of my method of treatment in the case of children and of the results that I have obtained. If, for instance, I observe in a child, at the same time, a high bodily temperature and ataxo-adynamic phenomena, I prescribe from the beginning baths at a temperature of 35° C., of a quarter of an hour duration, progressively diminishing the temperature of the baths to 25° C. The baths are renewed every three hours, but this rule is not absolute, and generally our guide should be the march of the disease, particularly in regard to the amount of fever. The baths then, should be renewed according to the degree of the hyperthermic condition of the patient. This practice which, I assure you, has nothing of a dogmatic character, has given me good results, and you have observed a good example in the case of our third patient. Therefore, to conclude, in children you should always advise the application of cold baths in those cases especially that exhibit ataxo-adynamic symptoms, but abstain from ordering them when there is only a condition of hyperthermia. I will repeat, that a high temperature by itself is of no consequence in the case of children. To this therapeutic measure (generally applied in all cases), you will add an enema, night and morning; if the stools are offensive you will order an injection of borated water slightly aromatized. For drinks, lemonades or some mixture with syrup of orange should be given. The diet should consist, during the febrile period, of broths. You have not heard me speak of milk. The reason is that, according to my experience, milk is not an entirely proper article of food in the typhoid fever of children. With few exceptional cases, milk is badly digested and its administration is followed by a slight exacerbation of fever. Therefore, I prefer to give it during the period of convalescence. In advanced stages of the disease, I prescribe claret, rum, brandy or Malaga.

Such is the hygienic treatment which I apply to typhoid children; but the medicinal treatment is as equally important. If the young patient is laboring under a state of agitation, I prescribe the following mixture:

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| Hydrate of chloral | gramme 0.50. |
| Tincture of musk | gtt. xx. |
| Linden-tree water | grammes lxxx. |
| Syrup of orange flowers | grammes xx. |

This to be administered in dessertspoonful doses in the course of 24 hours.

I prefer chloral to the bromide of potassium on account of the digestive disturbances which the latter remedy is apt to produce. If the child complains of headache, I give small doses of the syrup of codeine; but bear in mind that this is the only opiated preparation which is to be employed in infantile typhoid fever. The extract of quinquina which is frequently used in the enteric fever of adults, ought not to be administered to children. In fact, I will state that the extract produces disorders of digestion and provokes a loss of appetite, especially for those articles of food most advantageous to these young patients.

At the beginning of the 15th day of the disease, I prescribe the perchloride of iron in the following manner: At first, 1 drop every two hours, afterwards double the dose for about two or three days. This remedy can be given in a little water, sweetened or not, after the first mouthfuls of broth. Once taken, the child is allowed to finish his cup of broth. The perchloride of iron is a very valuable remedy in the treatment of infantile typhoid fever. It has given me, in a large number of cases, very good results. The medicament acts not only as a tonic, but it also appears to aid digestion, and thus, it is entitled to its continued administration during the period of convalescence. I insist upon the use of the perchloride of iron, and you will do well in prescribing it also.

I have said nothing so far in regard to the use of quinine. I have purposely left for the last my remarks about this drug. In all cases of infantile typhoid fever you must administer, from the very beginning, the sulphate, and you must continue it during the whole period of the disorder. You will cease its ingestion only when defervescence has been completely established. The doses of the drug will vary according to the age of the patient and the physiological effects produced.—Translated from *Le Bulletin Medical*, Nov. 15th, 1891.

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In consequence of the remarkable success claimed in the treatment of drunkenness with hypodermic injections of strychnine, this method of treatment was tried in the city hospital in Görlitz, Silesio, but the results were almost entirely negative.

## CHRONIC PELVIC PERITONITIS—LACERATION OF CERVIX WITH RETROVERSION AND PARTIAL PROLAPSE.

BY M. D. MANN, M. D.,

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*Gentlemen*:—This woman has come to get an opinion. She is twenty-four, has been married six years, has had no children. She was first unwell when sixteen. She has menstruated at intervals sometimes of four weeks, sometimes of three, sometimes she flows a good deal, sometimes very little. Since she has been married there has been more flowing. It was not painful when it first began but it has been so since marriage. She first began to feel ill five years ago. She had the ague and then scarlet fever during the first year of her married life and she had never quite recovered her strength. She complains of pain in her side. She says she has had a kind of paralytic stroke affecting the left side and even now her left arm is not as strong as it was. The same condition obtains in the left leg and foot. The stroke came on suddenly while she was walking. She did not become unconscious but she could not talk for three or four days. She was almost totally incapacitated for a week or two and for four or five months she was quite weak in the side and could do very little work.

The pain of which she now complains, begins in the left ovarian region and runs through to her back. It is worse when she is unwell and especially just at the conclusion of menstruation. Her period lasts sometimes three or four days, sometimes two weeks. She does no work except about her house, and even that tires her a great deal, and she has to lie down frequently during the day. Her bowels are regular except that sometimes she has to use an injection. The movements are sometimes quite painful.

You hear the history of this case and it is sufficiently common and characteristic. Here is a woman who is in comparatively good health until she gets married. Then she has a sickness in her first year of married life from which she recovers slowly, following this she has what she calls a stroke of paralysis from which she recovers but gradually and partially. About a year ago her health again began to fail. She complains of pain in the ovarian region, backache and general inability to work. What can we say as to the diagnosis of such a case? It might be almost anything. We cannot make a diagnosis although we might imagine what the condition is. Just before I brought her into clinic, I made an examination and I found that on the left side of the pelvis behind the broad ligament, there was a mass of something which did not belong there. I could feel this through the vagina and by examining through the rectum I could feel it very distinctly. Pressure over this mass from the inside caused a great deal of pain and when I made bi-manual palpation she evidently was hurt considerably. There could be but one thing, with this history and with what I find by physical examination to account for her trouble, and that is some pelvic inflammation. It is a little difficult to trace the history of it and to know exactly when it began but probably there was a specific origin for it since the trouble increased greatly soon after marriage and she never has been regular in her menstruation since marriage, and since then she has flowed a good deal more. Probably there was an old gleet existing in the husband at the time of marriage or perhaps a more recent urethritis. It is impossible to tell at this late date just how the trouble originated. However that may be, she has been a great deal worse since the attack a year ago. The pain and suffering referred to the left side has made her a miserable invalid since then. What is the significance of the pelvic mass which I have felt in my examination? It does not mean a pelvic cellulitis, as we used to think, but a pelvic peritonitis having its origin in the Fallopian tube. I cannot tell you its exact cause, but I can tell you its nature. The Fallopian tube is inflamed, prolapsed, knitted together with the ovary into a mass by adhesions and bound to the broad ligament behind. On the other side we can feel little or nothing, and there is no tenderness. At the same time, there may be a less degree of trouble there. The pelvic peritonitis is very apt to be worse on one side than on the other. It is very rare to find one side diseased and the other entirely healthy.

The important question is, what we can do for the patient. She is poor and her husband depends upon her to manage the house. It is exceedingly necessary for her and him that she should have her health and be able to work. It is a question almost between the poor-house and health. What can we

do to help this woman? These cases of pelvic inflammation are very difficult to handle. There is not, in all probability, a pus tube in this instance. The mass that I feel is quite small, very hard, it is not low down in the pelvis and does not give the impression of a large distended tube but of a thickening of tissues and agglutination to other parts by peritonitis. At the same time it causes a great deal of local and reflex pain. There is also intercostal neuralgia which goes so commonly with these troubles, although women often think that the pain is due to heart disease. There is a very close nervous connection between the left ovary and the intercostal nerves, as was pointed out by Fothergill a number of years ago; there is a direct channel for reflex disturbances.

This woman has had a certain amount of treatment but it has done her little good. She has been treated at the Dispensary a year with local applications, douches, iodine, tampons, etc. When she first came she could scarcely walk and for a few months she was benefited, but of late she has made no progress. She probably will not improve further on such treatment. I do not know anything further to do, unless it be to try electricity or perform laparotomy. I have not been satisfied with the use of galvanism in the treatment of these cases. It may be because I do not know how to use it, or it may be because it does not do any good. I have tried it myself and I have seen it tried by those who claim to be experts in its use and without improvement on the part of the patient. A long course of "rest cure" might do this woman some good, but it is absolutely beyond her means. I do not see anything left except a laparotomy and I should expect that by the removal of these diseased organs the patient would be allowed to regain her health. The function of the organs is, of course, destroyed so that the tube could not carry an ovum, but the ovary probably cannot even give off an ovum. The woman would much rather have her health than the exceedingly remote possibility of bearing children. I shall suggest to her an operation, telling her frankly that I do not know anything else that will cure her. The risk of laparotomy is comparatively slight and the chances of good results very great.

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PYOKTANIN, though no better, perhaps, than corrosive chloride or some other articles to prevent wounds becoming septic, is, however, much better to disinfect a wound which has become septic or infected.

## COMMUNICATIONS.

### THE IMPORTANCE OF BLOOD CLOT IN TREATING DEAD SPACES.*

BY MONT. LINVILLE, M. D.,
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Since the days of Ambrose Paré the progress of surgery has been steadily onward and upward. History is full of illustrious names; but in the years to come the name of Lister will stand out more prominent than all others. In teaching us the importance of cleanliness and the use of antiseptics and the drainage tube, he has not only conferred the greatest boon on suffering humanity, but gave medical men of the present day an impetus to learn how to assist nature in healing wounds without interfering with her laws.

In olden times the blood was considered the plastic material which filled the holes like the glue and cement which stick together the edges of a wound, but now we fear the most dangerous results from its decomposition, and use our best efforts to keep a wound free from it, and the surgeon who fails to check hæmorrhage will look in vain for successful results from his antiseptic technique. But when we change our views on any question, the pendulum of thought often swings too far in the opposite direction. May we not have fallen into the same error on this subject.

For more than twenty years the eyes of every thinking surgeon have been turned towards the great Lister, who has never lost an opportunity to emphasize wound drainage, and he is still untiring in his efforts to discover the best means for so doing. But during the last eight years other great minds have proposed methods for healing wounds without drainage tubes. Seven years ago Neuber contributed an interesting article on this subject. He recommended irrigation with a sterilized solution of salt, and drainage by loose stitching. To get rid of dead spaces he advised buried sutures inverted stitches, flap implantations and compression from without, but this plan is not only tedious, but often impossible to thoroughly obliterate the dead spaces in wounds.

I have worked until I was nearly exhausted in trying to carry out this plan of

*Read before the Association of the Surgeons of the Pennsylvania Railroad Company in Chicago, Oct. 20th, 1891.

treatment, but I do not believe that I ever thoroughly succeeded in obliterating the dead spaces. More than once in such cases I have been surprised and gratified to find that the wounds healed by the first intention just as regularly as the most simple wound without dead spaces.

Recently my mind has conceived the idea that there is something in Schede's theory of wounds healing under the moist blood scab.

He says, "It has required only a moderate experience with antiseptic surgery to enable us to recognize that even large blood clots in open wounds do not necessarily undergo destruction or decomposition, that they do not necessarily give rise to inflammation and accidental diseases, but that they take on changes which we may designate as organization of the blood clot, and which one may compare with the conversion of the thrombus in ligated blood vessels." This calls to my mind the words of the immortal John Hunter, which I first heard when a student from the lips of that grand old man Professor Gross: "In many deep-seated wounds where all the parts have remained in contact, those underneath will unite much better if the surface be allowed to scab. Compound fractures [more especially where the external wound is small] should be allowed to heal in the same way; for by preventing the blood to scab upon the wound either by itself or when soaked in lint, the parts underneath will unite, the blood under the scab becomes vacular, and the union will be complete even when the parts are not in contact. Many wounds ought to be allowed to scab in which this process is now prevented; and this arises, I believe, from the conceit of surgeons who think themselves possessed of powers superior to nature, and therefore have introduced the practice of making sores of all wounds."

Gentlemen, the author of these words was certainly far in advance of his time. I am aware that I stand on debatable ground, and that many may assail my position, but I only claim to be an humble learner, and if I can provoke a discussion on the few points which I may be able to hint at in this short paper, perhaps I may be able to absorb some practical knowledge that will pay me for my long journey to this meeting.

I honestly believe that the blood clot is the important factor in healing many wounds where we have dead spaces. And that too many surgeons do harm by trying to get rid of it, by the use of drainage tubes, and the application of strong antiseptic solutions.

Do not understand me to say that I am opposed to antiseptics or the use of drainage tubes. I believe that it is our first and most important duty, to thoroughly antisepticize our hands and the external portion of the wound, but we meet with many cases where the wound is deep, with large dead spaces, that I believe the use of carbolic acid or corrosive sublimate destroys the physical and, perhaps, the chemical characters of the blood, and produces a superficial necrosis which must retard healing. In operations upon diseased bones, where it is impossible to remove every particle of diseased bone or tissue, and where a profuse discharge is sure to follow, I am in favor of drainage, but in all wounds where the cavity is composed of healthy tissue, I believe that nature is superior to a drainage tube. In amputations if we cut our flaps short and neat, stitch the muscles and close the flaps by buried skin sutures there is no reason why we should not have rapid healing by first intention. I will very briefly relate the history of a few cases which I have treated during the last three years.

Case I.—Miss W., age 55, consulted me last September for carcinoma of right mammary gland; the tumor extended across the sternum and the axillary glands were involved. I found it necessary to remove the breast, pectoralis fascia, a large portion of the pectoralis major, the glands and adipose tissue in axilla, and skin fascia and muscles down to the sternum and ribs, three inches wide and five inches in length, this portion of the wound was without a covering, and presented a frightful appearance, I permitted the wound to fill with a blood clot, after which it was dressed antiseptically. I did not open it for a week, when I found the blood clot organized and a healthy scab covering the entire wound, which was completely healed in twenty-eight days. The patient has gained twenty pounds and thus far there is no sign of a return of the disease.

Let me digress for a moment, while I say that experience teaches me that the only hope of permanent cure in carcinoma of the mammary gland is not only to remove the entire gland but the axillary glands and a liberal portion of the surrounding tissue. Even the pectoralis major muscle nearly up to its insertion into the arm.

Case II.—Railroad brakeman injured while coupling cars. There was a compound comminuted fracture of the right arm, involving the elbow joint, which felt like a sack of small bones; the skin was broken

through in five places; there had been profuse hæmorrhage but was checked, or nearly so, by blood clots when I saw the patient. The arterial circulation being good I decided to make an effort to save the arm. I enlarged the wounds sufficient to remove lacerated pieces of muscles, and fragments of the humerus, olecranon and condyles of elbow joint. I then placed the arm in a solution of corrosive sublimate one to one thousand for several minutes; by this time the clots which had been broken up were reformed. No stitches were used, the arm after being dressed with iodoform gauze and loose bandage was placed on a straight splint. I redressed it in five days and found the blood clots red and healthy, and that they would bleed if gently touched with a probe. In four weeks the wounds were healed, and although the arm is weakened he has good motion in the joint.

Case III.—A German merchant, who was an excessive beer drinker, consulted me four years ago on account of a running sore on the anterior portion of right leg. I found that the anterior portion of tibia was diseased about three inches in length, also the soft parts for a much larger circumference. I removed every particle of diseased bone and tissue with a curette, and allowed the cavity to fill with a clot. I then applied the usual dressing, and on the fourth day found the clot was organized and healthy; this case gradually progressed to complete recovery. The cavity was filled so as to make the limb smooth and natural.

If time permitted I could relate several cases of compound fracture of the leg where there was not only loss of bone, but of the soft parts over the seat of the fracture, in which nature repaired the injury by organized blood-clot.

The dressing of this class of wounds is an important matter; gutta-percha tissue is an excellent protection, and enables the surgeon to avoid injuring or tearing away the scab during subsequent dressings. The old habit of dressing wounds every day or two, and each time tearing the wound open by so doing, was barbarous and I often wonder that nature did not rebell with such emphasis as more frequently to prevent recovery.

The less we disturb a wound the better; in all favorable cases of amputations one or two dressings should be sufficient. In the past much harm has been done, and many limbs and even lives have been sacrificed by tight bandaging. I am glad that this matter is being constantly agitated. We always know better, but it is so easy to overdo it that we constantly need to be reminded of the danger.

The buried suture in many cases is a great improvement. How often have we found the holes in the skin produced by the stitches full of matter, and the wound healed by first intention. The skin, no matter how thoroughly disinfected, may contain the germs for producing septic trouble, but the cavity of a wound if in a normal condition may be capable of disposing of large quantities of micro-organisms.

A frequent cause of suppuration in infected wounds is obstructed circulation, and nothing is so liable to cause it as tight ligatures and sutures. Experience teaches me that I have committed more than one sin against nature in this way during the early years of my practice. Methinks it a good plan to use weak silk, and if we occasionally break it we are reminded that we are using too much force.

I hint at these small matters, because they all belong to the one great family in wound treatment, and it will not do to neglect the most minute detail if we wish for reasonable success.

We may be successful in treating wounds with dead spaces, either by obliteration, drainage or blood clot, providing we thoroughly disinfect the skin and everything that touches the patient.

In conclusion let me say that while I do not recommend dispensing entirely with the drainage tube, there is a strong tendency in that direction among some of the bright surgeons of to-day. We love to boast that surgery is a true science, but we never should forget that nature is the great physician, and that the best we can do, is to assist her in the simplest manner possible.

The blood clot theory is not new. It is being tried here and there by progressive men who are loud in its praise. We live in the age of rapid thought, and the physician who loves the profession, and works for something more valuable than money, must be devoted to hard study and extensive reading.

The multiplicity of ideas requires him to have a clear brain and quick judgment if he wishes to stand somewhere near the front rank, and to be a blessing to suffering humanity. I am reminded of the lines often quoted by the August Nestor:

> "A wise physician our wounds to heal,
> Is more than armys to the public weal."

And again those quoted by Paulus from that grand old poet Homer:

"The man of medicine can in worth with many warriors vie,
Who knows the weapons to excise, and soothing salves apply."

## A CASE OF THERMIC FEVER COMPLICATED BY CROUPOUS PNEUMONIA.

BY CHARLES B. WILLIAMS, M. D.,
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John P. L., age 27, white, a vigorous, healthy looking man, employed at Spreckles' sugar refinery, having been overcome by the heat was brought to the Pennsylvania Hospital by the police patrol on June 17, 1891, during the service of Dr. Morris J. Lewis. On admission at 2.35 P. M. his temperature per rectum was 110°; pulse 160; resp. 42. He was intensely cyanosed about the face only. The rest of his body was burning hot to the touch. His eyes were markedly congested—the pupils were contracted and the eyeballs were rolled upwards. He was in a state of profound unconsciousness.

His breathing was rapid, stertorous and labored and accompanied with a loud rattling in his throat. His bowels were moving involuntarily when he was brought in and moved continuously for 20 minutes after admission. He had had convulsions before admission but none after. His pulse was scarcely perceptible at the wrists. It could be counted at the carotids and by the stethoscope. There was a profuse, frothy, mucous discharge from his nostrils.

At 2.35 P. M. he was given an iced enema and an hypodermic of tr. digitalis ♏x with whiskey ♏xv. His bowels continued to move for some time after the iced enema had been given. At 2.55 P. M. his temperature had fallen to 103⅘°; pulse 160; resp. 52. He was given another hypodermic of digitalis and whiskey. At 3.10 P. M. his temp. and pulse were the same but his respirations were 40 per minute. He was now given an hypodermic of strychniæ sulph. gr. $\frac{1}{30}$. At 3.20 P. M. the first sign of reaction occurred. His temp. was 102⅘°; pulse. 136; resp. 32. It was now that the ice rubbing produced a marked redness over his body surface, and the spraying from the hose would cause him to writhe and twist about; for previous to this, while the ice and hose were being applied he had remained quite immovable. Between 3.20 and 3.35 P. M. the hose was again applied. His temp. at 3.35 P. M. was 102½°; pulse 124; resp. 34. The hose was now applied for the last time between 3.35 and 3.50 P. M. At 3.50 P. M. his temp. had fallen to 100⅘°; pulse 110; resp. 28. He was now thoroughly dried and placed upon another bed. At 4.05 P. M. his temperature was 99°; pulse 120; resp. 32. He seemed very restless and was writhing and twisting about the bed a great deal. He was accordingly given an hypodermic of morphiæ gr. ¼ et atropiæ gr. $\frac{1}{120}$. At 4.20 P. M. temp. was 98⅘°; pulse 132; resp. 32. At 5 P. M. his pulse still continued to be very rapid and feeble. Ordered another hypodermic of tr. digitalis ♏x and whiskey ♏xv. At 5.20 P. M. his temp. arose to 104°; pulse 120; resp. 32. Had another hypodermic of digitalis and whiskey. At 5.45 P. M. his pulse still remained unchanged. Ordered him hypodermics of whiskey every fifteen minutes until 8.30 P. M. From 6 P. M. until 8.30 P. M. he seemed very restless and twitchy and he was therefore given another hypodermic of morphiæ gr. ¼. During this time he also received two more hypodermics of tr. digitalis and whiskey. His pulse could now be distinctly felt at the radials.

As he still continued very restless, his wrists and ankles were strapped to the bed. When the patient was removed to the ward at 8.30 P. M. he was still in an unconscious condition. He was ordered to have an ice cap to his head and hypodermics of whiskey every half hour until 11 P. M. After which time he had them hourly with spts. ammon. aromat. f℥ss. by mouth. The patient slept through most of the night and awakened in the morning and desired to know where he was—how he had come to be in the Hospital and why the straps were on his wrists and ankles. Temperature was now 99⅘°; pulse 98; respiration 18. His pulse was rather feeble and although his general condition was remarkably improved yet he seemed rather dull and slept a good deal. His urine examination now showed a specific gravity of 1022—was clear, yellow, acid and contained albumen. Microscopical examination showed numerous hyaline and epithelial with pale granular casts.

On the following day, 19th, he seemed muddled and dull of comprehension and when asked a question he would reply in such a manner as almost to indicate that he had been having a little too much spiritus frumenti. His pulse was 84 and of fair volume, and respiration 28. His stimulus and digitalis were immediately discontinued and

he was given sodii brom. gr. xv. t. d. and also calomel gr. ½ et sodii bicarb. gr. v. q s. h. The following note was made on this day: There is no left knee-jerk and none on reinforcement. His feet have a curious mottled appearance. He has good power and grip in both hands. His face draws up more on the right side than on the left. His tongue comes out straight, but possibly it turns a trifle towards the left. There is no difence to be seen in the movement of his forehead. He can read understandingly, and speaks in a thick voice as if he had something in his mouth. Right pupil is a trifle larger than the left. Pupils react to light and accommodation. He has a slight elbow jerk. On June 21st he became delirious and continued so more or less until the end of the month. He had numerous delusions and hallucinations and could not be reasoned out of them. His temperature during this time ranged between 99°+ in the morning to 102–3 and 4+ in the evening. On the 27th he began coughing a good deal. His sputum was profuse, greenish, muco-purulent and tenacious. On July 1st physical examination of his chest showed that fremitus was most marked over his right chest anterior. Percussion note good and very resonant; expiration over right chest was rather prolonged with a few cooing rales. Posterior—right base, percussion note is flat, tubular breathing, ægophony and sub-crepitant rales. Three days later the following note was made: Percussion note is still flat over the right lung posterior, tubular breathing and sub-crepitant rales can be heard in the right spinal gutter. Of late his temperature has been keeping close to the normal in the day time with an evening rise to 103° or 104°. + His temperature usually begins to rise from 6 P. M. to 11 P. M., when it reaches the maximum 104°. Antikamnia in repeated doses of gr. jss and gr. iij seemed to have no effect in controlling this rise of temperature. The same could be said of antipyrin and quinine. The latter drug having been administered as high as gr. xxxvi. per diem. Urine examination made on July 10th, showed a specific gravity of 1018, was clear, yellow, slightly acid, albumen and casts negative, some triple phosphates.

In addition to the above drugs the patient was receiving ammon. carb. gr. v. every four hours besides milk punch t. d.

On July 18th the following note was made: Chest—There is good movement anterior and but slight impairment in resonance at the right apex. A few moist râles can be heard posterior on the right side and mostly at the root of the lung. He perspires profusely at night and especially after the small doses of antikamnia.

On the 16th of August his chest seemed to be perfectly clear, and his temperature has been keeping within the limits of 101½°. The attack of croupous pneumonia caused the patient to emaciate rapidly but after his chest began to clear up and his cough had ceased he soon commenced to regain his strength and weight.

On September 4th, his temperature reached normal and showed no inclination to rise after that time—his cough had ceased entirely and he seemed to be in perfect health. He was discharged cured, on September 19th, 1891.

The patient's temperature chart is a curiosity. It is 8 feet 2 inches in length and its record covers a period of three months with the exception of two days. In all of this time the patient's temperature never reached the normal to stay any length of time until a few days before his discharge, when it showed no inclination to rise again and he left the Hospital—a picture of health. At the present time the patient is doing well and he has no return of bad symptoms.

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## FRACTURES AND INJURIES OF THE SPINE IN THE CERVICAL REGION—FRACTURE OF THE THIRD VERTEBRA—CERVICAL SPINAL HÆMORRHAGE, FRACTURE OF ODONTOID, FRACTURE OF FOURTH VERTEBRA.*

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The following group of injuries to the spine, taken in connection with the cases of laminectomy reported by me in the *Transactions of the College of Physicians*, Philadelphia, January, 1890, and February, 1891, show that the prognosis in the majority of the cases of injury to the spine is determined almost entirely by the initial lesions—*i. e.*, the amount of injury which has been primarily inflicted upon the cord. In nearly all cases of spinal fracture the substance of the cord receives severe contusions or lacerations, and the resultant symptoms are not only dangerous, but it frequently happens that death ensues in a short time.

*Read before the Philadelphia County Medical Society, December 9th, 1891.

The first case shows that even very positive bone injury in the cervical region may produce symptoms of but moderate severity, provided the cord be uninjured.

*Fracture of Third Cervical Vertebra.*—E. R., male, aged thirteen years, fell through an elevator shaft some thirty feet. He was picked up unconscious and removed to the Hospital. Upon examination a large hæmatoma was discovered over the occiput, but there were no external evidences of injury. The head was retracted and turned markedly backward; it could be bent only slightly from side to side. Rotation was possible only to a slight degree. A finger passed into the mouth discovered a distinct prominence behind the posterior wall of the pharynx corresponding to the third cervical vertebra. The rigidity of the neck muscles was great. There was no paralysis, no cough, no loss of sensation, nor could crepitus be discovered. There was no evidences of severe pressure upon the cord. Flexion, extension, and rotation were almost impossible.

Under strong extension and counter-extension applied upward from the head and downward from the body the deformity was markedly reduced. A plaster-of-Paris collar applied while extension was maintained was accurately fitted, so as to keep the head in a fixed position. This bandage was arranged so as to press on the occiput as high as the prominence, also to press upon the mastoid and temporal bones, and to curve forward so as to encircle the lower jaw. It then accurately fitted the neck from whence it extended to the shoulders and passed down loosely to envelop the upper part of the thorax. This maintained the head accurately in position and prevented any movement of the upper portion of the trunk, neck, or head. This was applied in place of extension and counter-extension on account of the sensitive condition of the hæmatoma over the occiput. After the tenderness from the blood tumor had disappeared, weight and pulley extension were applied to the head and feet up to the point of comfortable endurance. The plaster envelopment was sawn open and permitted to remain as a splint to prevent lateral rotation and flexion.

He was kept in this position for six weeks. There was no impairment of motion or sensation during this time. The extension apparatus was then removed and an accurately fitted neck splint of plaster-of-Paris was applied. He wore this with comfort six weeks longer. At the end of this time examination of the pharynx showed that while there was still a slight prominence in the posterior part of his throat, the deformity was much less evident than at the time of the injury. There was still less rigidity, but no deviation of the vertebral column could be discovered. The absence of pressure-symptoms resulting from the injury was a point of special interest. A year later he could move his head in all directions, although motion of the chin to the right was limited. Flexion seemed perfect. It is but seldom that a patient either breaks or dislocates his neck without more serious symptoms.

*Cervical Spinal Hæmorrhage.*—W. M., aged eighteen years, was injured by diving eighteen feet into a pool of water two feet deep. He struck his head and the back of his head on the bottom of the pool. He was immediately pulled out by his comrades and was found to be unconscious. He remained in this state two hours. When first seen, some time after, he was blanched and pale, and complained of a pain in the back of his neck and beneath the shoulders. Sensibility was present throughout body and legs but apparently diminished. There was no opisthotonos, and no rigidity of the neck other than that motion gave slight pain. There was no tenderness over the region of the spinal cord, except slight pain in the lower cervical region. There was no visible displacement of the vertebræ, and no positive evidence of dislocation or of fracture. Flexion, extension, and rotation of the head were perfect and accompanied with only slight pain. The spinal column could be flexed and extended normally. Motion and extension in both arms, body, and legs seemed in good condition, except as regards sensibility as above noted.

He was partially conscious and could answer questions intelligibly, but with an apparent effort of the will, and his speech was slow. There was anæsthesia of both hands, especially on the ulnar side. He complained of pain in the region indicated. There was constant and decided priapism.

This condition continued until about seven hours after the accident, when he slowly seemed to lose power of the hands and forearms on both sides, commencing apparently in the region supplied by the ulnar nerve. Also there was progressive loss of sensation in both hands and forearms. Both brachial plexuses were sensitive to the touch, but not painful. Priapism still continued, but the urine was voided naturally. The scrotum was anæsthetic and remained so for several days, and uncertain areas of the abdomen

seemed in the same condition, but his answers to questions were not very satisfactory. The legs retained both motion and sensation although both functions were apparently diminished.

The patient seemed to rouse from his unconsciousness at the end of the first hour and was moderately intelligent.

Up to this time extension made upon the spinal column by means of the head gave relief from pain, therefore, an extension and counter-extension apparatus was applied to the head and extremities, and continued traction was maintained.

Loss of motion and sensation increased during the next twenty-four hours until the patient was able only to move his arms feebly; fingers immovable. Sensation was entirely absent in both hands in the region supplied by the ulnar nerve. Sensation was impaired in other regions of the forearm and hands.

During the next two days there was apparently no change either as regards motion or sensation, but on the following day both functions began slowly to return.

At the end of the fifth day he could raise his arms, but only for a moment. When the extensor muscles were required to fulfill their functions the arm immediately fell. There was still a tendency to priapism, but the condition was not constant, the scrotum was still anæsthetic. Temperature, pulse, and respiration remained unaltered.

Continuous extension was maintained, and as there was no paralysis it was deemed probable that all hæmorrhage within the canal had ceased.

Motion and sensation returned to a slight degree in the thumb and fingers of the hand and in the arm, until gradually both functions were restored almost entirely. The scrotum remained anæsthetic for ten days.

Fifteen days later he could grasp an object with considerable firmness.

A trapeze was rigged over the bed so as to exercise the arms while extension was being maintained. An ischio-rectal abscess discharged for two weeks and then healed.

In eight weeks had thoroughly recovered and presented no abnormal symptoms. Motion and sensation complete.

A peculiar condition regarding this case was that after the condition of shock had passed away there was no serious symptoms until the probable occurrence of hæmorrhage had begun to make pressure upon the spinal cord and thus to interfere with its functions. The occurrence of paralysis upon both sides instead of upon one, and the length of time after the injury showed that the symptoms must have been largely due to gradual compression.

*Fracture of the Odontoid Process of Axis with Dislocation of Atlas.*—C., aged 18 years, fell 20 feet, striking upon his head. He was picked up stunned, but soon regained consciousness. He was able to walk to his home, several blocks distant, and to talk with his friends. An hour and a half later he was perfectly rational, talked freely and pleasantly, and complained of no pain when at rest; he simply desired to be permitted to sleep. He was quiet, but would suddenly start with an anxious look. The trunk and extremities were cold; pulse 85, feeble. Pupils equal, but failed to respond readily to light. The head was thrown backward with the occiput to the right, but he complained of no pain. The chin protruded, and the thyroid gland was prominent. Any movement or rotation of the head toward the right was accompanied with pain. Motion to the left was painless for a quarter of a circle, but any greater motion caused discomfort. There was no contusion or laceration of any part of the body; no depression of the skull, nor any evidences of fracture of the cranium. Pressure over the cervical region gave severe pain. The spinous processes of the cervical vertebræ were in line up to the third, but above this was a marked depression, while a little higher the position of the atlas was slightly projecting to the right of the median line. Manipulation caused so much pain that ocular examination of the pharynx could not be made. Digital examination revealed a slight prominence of the second vertebral body.

*Diagnosis.*—Dislocation of the axis from the atlas; probable fracture of odontoid.

During the night he slept at intervals, but roused at the slightest noise. There was no pain, except upon the movement of the head.

In the morning he took nourishment, and complained of no suffering. He ate a light breakfast, and was anxious to go to his business. Three hours later he began to grow drowsy, and in two hours became semi-unconscious, but could still be roused. He answered questions intelligently, but closed his eyes as soon as he had ceased speaking. The tongue was protruded straight from the mouth, and with difficulty; the pupils responded to light; the right eye was a little more responsive than the left. There was no paralysis, except of the bladder, the urine not having been passed since the acci-

dent. The catheter secured eight ounces of apparently normal urine. Pulse was 80, full; respiration 16, deep but not snoring.

Twenty hours after the injury the pulse was 48; respiration 12, somewhat stertorous, not puffy nor blowing. Could be roused only with effort. Answered unintelligibly; occasionally, however, an articular word escaped. He constantly pulled at the bedclothes. The urine dribbled. Pupils were nearly the same size, but the left responded more readily to the light. At the junction of the forehead with the hair, for an inch and a half to the left of the media line, apparently the point where the head came in contact with the ground in the fall, the scalp was œdematous and there was a slight depression. Pressure upon several points in the same region gave similar pitting. No evidence of fracture.

No injury could be discovered in any portion of the body save the neck.

There was no paralysis of any portion of the body, but there was slight impairment of motion of the right arm and leg. The head could be moved with little more freedom toward the left, but a slight force caused the patient to cry out and to steady his head with his left hand. There was rather less deformity than at first at the back of the neck; the thyroid was not so prominent. Liquid food was taken without difficulty. He passed a restless night, constantly pulling at the bedclothes, tossing about on his couch, and muttering in delirium.

Forty hours after the injury it was noticed that he moved the right arm and leg less frequently although both members could still be brought into use by a special effort of will. Pupils as the day before; respiration also; pulse 60. The patient responded to loud shouting, but could give no intelligible answers, although frequent attempts at utterance were made. The urine dribbled constantly.

Seventy-two hours after the accident the pulse was 100; respiration 20. Increased loss of power, but members still capable of being moved.

Eighty-four hours after the injury the pulse was 130, feeble; respiration 24. Delirium less violent. Patient remained quiet, except when partially awakened. When roused by any cause the left hand still pulled the bedclothes. The right arm and leg were still capable of being moved slightly, but the muscular power was weakened. Unconsciouaness increased with total inability to speak. Bowels not moved since the accident. Pupils normal in size, still contracting under the influence of light. Liquid nourishment has been swallowed up to this time, but was now refused. Died quietly ninety-eight hours after the injury.

*Post-mortem.*—Examination of the neck alone was permitted. The posterior cervical muscles were filled with extravasated blood from the occiput to the fourth vertebra. The spinous prominence of the atlas lay to the right of that of the axis and on a plane posterior to it, causing the axis to appear as though it had been pushed forward. In reality, however, its position in relation to the third vertebra was normal—the atlas being the dislocated bone. The left inferior articular process lay behind the articular process of the axis, while the right inferior articular process of the atlas lay anteriorly. This displacement was permitted by a fracture of the odontoid process of the axis. One fracture extended directly across its base, while the other had broken off a small portion of the anterior surface—the line of the fracture being almost at right angles to the first. The odontoid process, however, was still held in position by the transverse odontoid ligature, which was unruptured. As noticed during life, the atlas could not be rotated to the right, while it could be turned to the left. Strong extension made upon the atlas permitted it with difficulty to be brought into position.

*Fracture of the Third, Fourth, and Fifth Laminæ; Death.*—W. P., aged forty years, fell from a scaffolding, a distance of twenty feet, striking the top of his head on a curb, and alighting as nearly as possible with the axis of his body in a straight line. When seen half an hour later he was suffering from shock. His pulse was 80, and his respiration feeble. He was perfectly conscious but indifferent to surroundings. There was a large, lacerated wound of the scalp four inches in length transversely across the forehead. In the region of the third and fourth vertebræ there was marked displacement forward of the third with prominence backward of the fourth dorsal spine. There was total paralysis of both motion and sensation, and of all parts of the body below the portion supplied by the corresponding nerves. Neither urine nor fæces had been passed since the accident. There was no priapism. Extension and counter-extension had no effect on the deformity.

The patient rallied for two hours, the pulse reaching 110 and the temperature 100°. He complained a great deal of pain in the back of his neck and shoulders. Soon

afterward the respiration became more hurried, the heart's action much more feeble, and although perfectly conscious for one or two hours, he soon sank into a state of drowsiness, and died ten hours later.

At the autopsy there was found a fracture of the body of the fourth dorsal, with fracture of the laminæ of the third, fourth, and fifth. The third was greatly displaced forward, carrying with it a fragment of the fourth. The cord was entirely torn across at the junction of the third with the fourth, and was pulpified for half an inch and compressed by the fragments of the other laminæ.

Laminæctomy would have relieved pressure, but would not have restored the crushed and torn cord.

## SUPRA-VAGINAL HYSTERECTOMY.*

BY J. M. BALDY, M. D.,

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It is not the object of this paper to discuss the different methods of surgical treatment for uterine tumors nor to more than incidentally touch upon their medicinal treatment. My personal practical experience in the surgical direction has been wholly that of supra-vaginal amputation, excepting in those cases of small uterine fibroids where it has been been found advisable to remove the appendages only. In this connection I may say that where the opportunity presents to choose between the removal of the appendages and the enlarged uterus itself, I always favor the removal of the diseased uterus, along with the tubes and ovaries. The one and only point which comes into consideration in this decision is whether or not the uterus is large enough to be delivered through the abdominal incision. If it can be delivered, the hysterectomy is always performed. To my mind one of the great advantages gained in hysterectomy, by the extra-peritoneal method, over oöphorectomy, is that no stump or raw surface is left in the peritoneal cavity to become the seat of suppuration, or to whose freshened surface loops of intestine can become adherent. In uncomplicated cases the operation amounts to little more than an exploratory incision, and in my opinion is as safe as an ovariotomy.

I have operated fifteen times for large uterine tumors. In fourteen cases the uterus was removed, but in the remaining case the operation was ended as an exploration. Of the fourteen finished operations, two died.

The patient whose tumor was not removed was a white woman about thirty-five years of age. The growth had existed for more than ten years. When she was first seen she was in bed, where she had been for some weeks, with an attack of abdominal pain. For months she had only been able to be about at odd times, and considered her life a burden. An operation had been proposed to her a long time before, and its dangers brought vividly before her eyes. She had continued to suffer from pain and hæmorrhage, until, in spite of her former fears, she was, at the time I saw her, determined to have the operation performed at all hazards. In spite of her long suffering she was still a strong, hearty-looking woman. The abdomen was opened at the Gynecean Hospital before a number of physicians, and the tumor found to extend above the pelvic brim. The intestines were adherent over it at various points, and had to be torn loose in order that a careful exploration could be made. The growth was found to be in the broad ligament,and was consequently immovable. The only adhesions which existed were the intestinal ones, which had been torn through. The removal of the tumor meant a complete enucleation of a solid growth, with all the chances of death from hæmorrhage which such procedure entails. It was decided wise to end the operation, explain the condition to the woman, and let her decide whether or not she desired to risk its removal at some subsequent time, or preferred a trial at electro-puncture. The result was a complete symptomatic cure. It is now some five or six months since the operation and the woman declares she has never been so well in her life; she attends to all her duties, goes to dances, and in other ways leads an active life. She declares that the tumor is rapidly decreasing in size, and is most confident that it will disappear altogether. She looked at me most sceptically when I told her it would not go away, and that some day all her old symptoms would come back.

The last time I saw her—a month ago—I was considerably staggered by the fact that there was an undoubted decrease in the size of the enlargement. It is barely possible that it might eventually turn out to be

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another example of a solid tumor becoming absorbed after an exploration; several such cases have been reported by Tait and others.

One of the points of greatest interest to me in this case is the fact that her relief is not dissimilar to what is claimed for the electrical treatment. Had she gone to Dr. Massey for that treatment, as I advised her to do, and which she would have done had she not gotten well so rapidly, electricity would have obtained the credit for the cure. As it is, the lesson taught should not be lost. Is it not possible that the great relief apparently obtained by the electrical treatment is at times a mere coincidence? Or would not any profound impression bring about a similar result in at least some of these cases?

The two cases which died were both very bad subjects for operation, and their deaths can in no way be used as an argument against the operation. The true deduction to be drawn from the result in these two cases is that the operation should not be left as a last resort, as is advocated by Keith and the electricians, but that it should be undertaken early, and while the tumor and patient are both in a good condition of health. It is the same old battle which had to be waged so long and so vigorously in the case of ovarian cysts, and the end will be just as surely the same—that is, removal before the woman's health is broken down, and before the tumor becomes unhealthy and adherent.

The first death occurred in a colored woman, about 35 years of age. The tumor was extremely irregular, and extended up to the ensiform cartilage. The patient was in the last stages of emaciation, and could only walk with the greatest difficulty. It was a serious question in the minds of some of my colleagues, who examined her, whether the disease was not splenic or a malignant omentum. I was rather inclined to the latter opinion myself, and went to the operating table prepared to meet any condition or complication whatever. The woman, her husband, and her doctor were all told that her chances for recovery without the operation were *nil;* with the operation that they were little better, although there were some and the only chance. They all agreed upon having the operation, and it was performed at the Polyclinic Hospital in the presence of my class. The omentum was adherent over the upper part of the tumor, which proved to be a nodular uterine fibroid. The omental vessels, which were as large as the radial, were tied and cut away, and the tumor delivered. The appendanges were diseased, and on one side the tube was distended with caseous matter. A good pedicle was secured, and the woman was in her bed within the hour. For five and a half days there was but a single bad symptom—a pulse between forty and fifty beats to the minute. The bowels were opening daily of their own accord, the temperature was normal, the appetite was good, and solid food was being taken with a relish. The abdomen was flat, and there was a minimum amount of pain. She was so well that her doctor was notified that she was safe. At the end of the fifth day she began to develop bad symptoms; the abdomen gradually distended, the pulse became rapid and hard, the temperature slightly elevated, the bowels obstinately constipated, food was refused, and finally vomiting set in, and she died at the end of three and a half days from septic peritonitis.

How it was contracted is still a mystery to me, as there was no drainage-tube used, and the dressings had not been touched since the day of the operation. The stump was perfectly dry and sweet.

The second case was that of a white woman, thirty-two years old. Three years ago she had consulted me, and refused operation, preferring electrical treatment. Off and on during this period she was under the care of Dr. Massey, and toward the end he resorted to electro-puncture through the vaginal vault. She stood this treatment fairly well for a few times, but finally suppuration occurred and a sinus track opened on the outside of the left labia. Pus discharged freely from both the vagina and the outside sinus. When Dr. Massey asked me to see her with the view to an operation, she was bed-fast and could barely move; she was profoundly septic, and too tender to handle. A finger in the vagina disclosed a fluctuating nodule, apparently of the fibroid, in the posterior cul-de-sac. This, taken in conjunction with the discharge of pus, made a pretty clear diagnosis of suppurating fibroid tumor following electro-puncture. I gave as my opinion that the only chance the woman had for her life was to get rid of the suppurating mass. Everybody concerned was willing and anxious that she should be given the chance, so I admitted her to my wards at St. Agnes's Hospital and performed the operation. The intestines and omentum were found adherent to the top of the tumor; the tumor was adherent in every direction to the pelvic walls; both ovaries were found posterior to the uterus, and both formed cysts as large as a goose-egg and an orange respectively; the tubes

were both diseased. The appendages were closely adherent, and only freed with difficulty. It was found that the fibroid was not suppurating, but that one of the ovarian cysts was. The puncture-needle in one or more of the treatments had entered this cyst, which was almost directly in the median line, and was the "fluctuating nodule" which was detected at the first examination. The external sinus opened into this cyst, and when the tumor was removed it left the open mouth of the sinus behind, at the same time deluging the whole pelvis with the dark, virulent cyst contents. A clean removal of the uterus and both appendages was secured; the pelvis was flushed out most carefully and thoroughly, and a drainage-tube was placed at the opening of the sinus track. In spite of all precautions, the whole pelvis suppurated, and the woman died of septicæmia on the sixth day.

Certain it is that neither of these deaths ought to weigh against the operation of hysterectomy in cases where the conditions are fairly favorable. If cases are ever to be considered last-resort ones, these come in that class, and had I been operating for statistics rather than for the good of the women, nothing would have induced me to touch either of them.

As I have said, twelve cases recovered, and went home well women. With one or two exceptions, they were all complicated cases—short, thick pedicles, or pedicles which had to be manufactured; diseased tubes and ovaries; adhesions. One case had a nodule as large as the fist protruding into the vagina from the cervix. This mass had been sloughing for weeks, and the woman was deeply septic. The operation, which was performed at the Gynecean Hospital, was done in two stages. With knife and scissors the sloughing tumor was removed from the vagina. The instruments were quickly changed, and a supra-vaginal amputation finished the operation. So septic was the woman, that when the stitches were removed on the eighth day the whole line of the incision gave way and the intestines protruded in a mass. They remained out for about two hours before I could be found to replace them. Fortunately, my assistant, Dr. A. C. Wood, reached the hospital earlier than myself, went immediately to work, and was just replacing the protruding mass as I walked into the operating-room. In spite of this accident she made a good recovery, and is to-day well and at her usual occupation. Two of the twelve patients who recovered from the operation are dead. The other ten, as far as I know, are alive and in better health than they have been for years. The two deaths were due, in one case, to a subsequent operation for an ovarian cyst; in the other, presumably to heart disease. About six weeks or two months after her return home, while in apparent perfect health, she was suddenly seized with syncope, and was dead within half an hour.

## Society Reports.

### PHILADELPHIA COUNTY MEDICAL SOCIETY.

*Stated Meeting, December 9th, 1891.*

Dr. De Forrest Willard read a paper on Fractures and Injuries of the Spine in the Cervical Region, etc. (See p. 49.)

Dr. J. W. Baldy read a paper on Supra-Vaginal Hysterectomy. (See p. 53.)

#### DISCUSSION.

Dr. G. Betton Massey:—Dr. Baldy is to be commended for going into the subsequent history of his cases—a thing that is not often done. I must, however, take issue with him in regard to the case which I referred to him. I feel perfectly confident that in each puncture the needle went into solid tissue, and not into a cyst. The position of the nodule was that of a retroflexed uterus, a mass clearly presenting in the posterior vaginal vault. Another reason against the view of Dr. Baldy is that at no time was there any reaction from the puncture. An abscess formed, opening on the inner side of the thigh, but I certainly saw no septic condition. The temperature was not above 99.5°, and my idea of sepsis is connected with a higher temperature than that. This was her condition up to the time of operation, and in fact the woman felt so well that I had great difficulty in prevailing on her to have the operation performed. I think that, possibly, if the operation had been limited to a vaginal procedure, with the object of evacuating the pus, the result might have been different.

I think that Dr. Baldy should also have mentioned that three years ago, when the woman came under his observation, she was exceedingly tender on both sides in the re-

gion of these diseased appendages. This makes me think that the diseased appendages had been present for a long time, acting as a hindrance to the electrical work. After this condition was revealed by section the better plan would have been to remove the appendages and allow the healthy fibroid to remain.

I also want to take exception to the suggestion that the results of electricity are simply coincidences. Coincidences are very fortunate adjuvants in most of our work, but they are a mighty poor thing to depend upon. I do not think that the electrical workers throughout the world who have treated these tumors, could have gotten their results simply through coincidences.

It might also be said that the result obtained in a case which I saw yesterday was a coincidence. This was a dispensary patient that had been treated by abdominal electro-puncture as well as by vaginal electro-puncture and intra-uterine applications. Up to the time of the use of abdominal puncture, in which three needles were simultaneously employed, the progress was slow. She was quite lame from pressure on the crural nerve, and possibly from diseased appendages. In this case operation was recently urged by Dr. Baldy. As the result of these punctures, and the use of a current of 100 to 200 milliampéres, she is now so comfortable that she has not time to come to the dispensary for further treatment, the tumor being very materially reduced in size. After being an object of charity for years, she is now earning a living at general housework within a half square of this hall.

Dr. Charles P. Noble:—My own experience with abdominal hysterectomy has not been very large, for the reason that most of the fibroids that I have seen have not especially troubled their possessors. The majority required only medical treatment. Probably not more than ten per cent. were especially troublesome, and many of the women did not know that they had any tumor. On the other hand, as we all know, fibroids can give rise to dangerous symptoms either from hæmorrhage or pressure.

In my work I have taken a view opposite to that of Dr. Baldy, particularly when the fibroid is from medium to small. If the symptoms demanded operation, I have felt that I was doing the patient the best service by removing the appendages and not disturbing the tumor. None of these cases have died, and the results have been all that could be desired. An objection to hysterectomy by the extra-peritoneal method is, that a weak spot is left in the abdominal wall which is liable to become the seat of hernia. This is one reason why I prefer removal of the appendages where it can be done. Where the appendages are diseased, particularly if pus is present and discharged into the pelvic cavity, this would influence me to remove the fibroid, particularly if it just about filled the pelvis. If this were not done, I should anticipate death from sepsis. It is practically impossible to wash out the pelvis if the tumor about fills it, and with the tumor present it is impossible to secure drainage.

I quite agree with those who urge early operations when the tumors are giving rise to trouble. I have witnessed some fifteen hysterectomies, although I have done but two myself. All of these cases have recovered. Where the operation is not complicated by adhesions, and where the patient is not broken down, I quite agree that the risk of the operation should not be greater than that of ovariotomy.

Dr. B. F. Baer:—I congratulate Dr. Baldy upon his success, and I believe that in the main I agree with him as to his advice in regard to operation. Where the appendages can be thoroughly removed, and the tumor is small, I should prefer to remove them, but in some cases they are so spread out that thorough removal is not possible. In such cases I prefer hysterectomy. The result in early hysterectomy is very good, almost as good as in ovariotomy, and I have become an advocate of early hysterectomy in the cases requiring operation. In my experience, fibroid tumors, as a rule, do give rise to trouble. The fact that the patient submits to an examination, and will submit to treatment by electricity, by puncture, and other methods of treatment more or less painful, and even to hysterectomy, shows that the disease does give rise to trouble. I cannot understand why it is that men of large experience say that fibroids are not attended with symptoms. It is seldom that fibroids actually kill, but often the patient would prefer death to a continuance of the suffering. When, therefore, the tumor is giving rise to symptoms, and is of such a nature that its removal is not very dangerous to life, and the appendages are readily *entirely* removable, I prefer hysterectomy.

Dr. Baldy did not discuss methods, and therefore I shall not take up that subject, except to say that I believe the pedicle should be treated intra-peritoneally whenever practicable—*i. e.*, when it is small. This certainly simplifies the operation, renders the after-treatment easier, and makes the

condition of the patient after recovery more satisfactory. The patient recovers as well, if not better, when the pedicle is dropped. In the case that died at the Polyclinic Hospital, I have thought the result might have been different had the pedicle been dropped. My impression is that the woman died of tympanites more than anything else, and, as is well known, the extra-peritoneal method of treating the pedicle is very apt to be followed by tympanites and obstruction of the bowel from traction on the rectum.

In regard to Dr. Massey's case, I can scarcely agree that the appendages could have been removed and the uterus left. One of the tubes was quite diseased and spread over the tumor. If any operation was indicated hysterectomy was the one, and the only portion of the technique that I would dissent from is the manner in which the pedicle was treated.

DR. BALDY:—In regard to the treatment of the pedicle I shall only say that I prefer to treat it outside, and my experience has been such that I shall always employ the extra-peritoneal method. The advantages, both theoretical and practical, are in favor of this plan.

In regard to Dr. Massey's case, I can only theorize as to the point of the puncture. I think myself that the majority of the punctures extend into the fibroid, but I know that some of them had been into the cyst, thus infecting it. The cyst was densely adherent at the point of puncture. I do not think that a fibroid will always show where a puncture has been made.

I have not seen much tympanitis after hysterectomy. Those cases that get well do not have distention. Where there is septic peritonitis there is always obstruction. In both of the fatal cases that I have reported there was well-marked septic peritonitis. Neither can I agree in regard to the liability to hernia after this operation. I have seen only one hernia after hysterectomy, and that occurred at the seat of the drainage-tube an inch above the pedicle. Although I see many cases after abdominal section coming back complaining, I have not seen one case of hysterectomy with post-operative trouble.

Many operators prefer oöphrectomy, and always do it when it can be done. I prefer hysterectomy, and give it the preference. In some cases you cannot remove the ovaries, and in others you may not be able to find the ovaries. In the case of exploratory operation reported, I found one tube which was distended with a bloody fluid, but I could not find the corresponding ovary or the ovary and tube of the opposite side.

Sometimes fibroids do not give rise to symptoms. One case operated on had very few symptoms. The girl had been told that she had a tumor, and came determined to have an operation, feeling that she would die if the tumor were not removed. The tumor was large. There was little hæmorrhage or pain, but there was one point which would in the opinion of many justify operation, and that was that the patient was only twenty-five years of age and the tumor was growing rapidly. The vast majority of fibroids I have seen have been advised to have nothing done. In future, with my present experience, I would consider such advice, in many of these cases, as unjustifiable.

## SELECTED FORMULÆ.

### SORE MOUTHS OF NURSING WOMEN.

℞ Listerine.....f℥ ij.
Glycerini.....f℥ ij.
Aquæ menth. pip.....f℥ ij.
M. Sig. Use a mouth wash two or three times a day.

—*Weekly Med. Rev.*

### A LOTION FOR THE ALOPECIA FOLLOWING ACUTE DISEASES.

The following formula is given (*L'Union Medicale*) as a preventive of the alopecia which is observed during convalescence from grave acute diseases:

℞ Alcohol, 80 per cent.....℥ 2¼.
Camphorated alcohol.....℥ 1¼.
Rum.....℥ 1¼.
Tinct. of cantharides.....℥ 1¼.
Glycerin.....℥ 1¼.
Essence of sandalwood, wintergreen and roses of each.....gtt. v.
Muriate of pilocarpine.....gr. vijss.

If the hair becomes dry, inunctions of oil of sweet almonds or castor oil may be made from time to time.—*Univ. Med. Mag.*

### HEADACHE.

In many cases rebellious to all other medication, Pescarolo has obtained good results with the following mixture:

℞ Antipyrin.....grammes iv.
Phenacetin..... " ij.
Antifebrin.....gramme j.

He supposes that the favorable action is due to a new body which is formed in the mixture.—*Nouveaux Rémedes*, June 8, 1891.

### COMPOUND WINE OF CREASOTE.

Dr. Fraenkel (*Il Raccoglitore Medico*, No. 14, 1891) gives the following to tuberculous

patients whose temperature is not high and in whose sputa the bacilli are not numerous:

℞ Creasote.....grammes xv.
Tinct. gentian..... " xxx.
Alcohol..... " cclv.
M. Two or three tablespoonfuls a day.

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## TREATMENT OF SWEATING HANDS.

The *Journal de Medecine* gives the following:

℞ Tinct. of belladonna.....ʒ j.
Cologne water.....ʒ j.
M. Add a little glycerin at the moment of using, and with the mixture rub the hands strongly. The hands should first be washed in soft water and thoroughly dried.

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## TREATMENT OF SYPHILIS DURING PREGNANCY.

E. Besnier recommends the following course of treatment:

1. Tonic medication. Good food, syrup of the iodide of iron, preparations of quinine.

2. Specific medication. Give every day one pill, as follows:

℞ Hydrargyri bichloridi.....gramme 0.010.
Extracti opii..... " 0.005.
Extracti gentianæ..... " 0.005.
Glycerinæ.....q. s. ut ft. massa. M.
Sig. For one pill.

3. At the same time prescribe iodide of potassium is doses of 0.50 to 1.0 gramme (7½ to 15 grains).

This treatment in continued throughout pregnancy, and the increase in the weight of the patient will testify to its efficiency.—*Revue Médico-Chirurgicale des Maladies des Femmes*, July 25, 1891.

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## FOR BLENORRHAGIA.

In the treatment of this disease, P. Thiery, (*Anal. de Malades Genito-urinaires*) recommends during the first period, abortive injections of nitrate of silver, and during the second period injections of iodoformated oil, frequent bathing, alkaline drinks, good diet, etc. After urination the following formula should be employed for injections:

℞ Iodoform, finely powdered.....grammes x.
Oil sweet almonds or glycerin. " lx.
A disinfectant substance, such as eucalyptus, vaniline, etc.q. s.
M. Sig. A syringeful of 10 c.c. is to be injected, and the injection kept in for 10 minutes.

—*La Médecine Moderne*, November 19, 1891.

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## ANTIPRURITICS IN URTICARIA.

Quinquad (*Deutsche Medicinische Wochenschrift*, 1891; No. 32).

### Lotion.

℞ Boric acid.....grammes xxx.
Chloral hydrate..... " v.
Distilled water..... " clxxx.
For external use.

### Dusting-powder.

℞ Salicylic acid.....grammes v.
Zinc oxide..... " xv.
Powdered starch..... " xxx.
For external use.

At the same time, alkalis are administered *internally*, and if these fail to produce an effect, sodium arseniate.

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## VARICOSE ULCERS.

Dr. J. Braun (*Lo Sperimentale*, No. 14, 1891) speaks highly of the following salve:

℞ Zinc. oxyd.....ʒ iv.
Lanolin.....ʒ iv.
Ung. emmolient.....ʒ jss.
M. f. ung. Apply locally on a piece of cloth a layer of the thickness of a knife-blade and over this a bandage.

Keep the patient abed until the ulcer has healed. If the ulcer has an unhealthy appearance the dressing should be removed three to four times daily.

The unguentum emmoliens of the Austrian Pharmacopœia is composed of white wax, 10 grammes; spermaceti, 20 grammes; oil of sweet almonds, 80 grammes; rose water, 20 grammes.

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## TREATMENT OF HYPERIDROSIS.

In the *Revue Général de Clinique et de Thérapeutique*, the following prescription for sweating of the hands and feet is given. The application is to be made night and morning. The part is first washed with hot water and immediately afterward the following ointment is applied:

℞ Ichthyol.....ʒ j.
Vaselin.....ʒ jss.

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## ANTISEPTIC ADHESIVE OINTMENT.

The following is an antiseptic adhesive ointment used at the hospital St. André:

℞ Zinci oxidi.....gr. ivss.
Zinci chloridi.....gr. xxijss.
Gelatinæ.....ʒ v.
Aquæ.....ʒ vijss.

This dressing protects the surface of wounds and dispenses with the use of bandages after operations. It is especially of service for the dressing of wounds on the face.—*Gaz. Hebdomadaire des Sciences Médicales*, August 16, 1891.

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## EPIDEMIC CEREBRO-SPINAL MENINGITIS.

Prof. M. V. Soubbatine (*Il Raccoglitore*, No. 12, 1891) employs the following in epidemic cerebro-spinal meningitis:

℞ Sodol. pur.....grammes 3.
Acetanilid..... " 1.80.
Sufficient for twelve pills. Three or four during twenty-four hours.

Soubbatine cured one severe case and Kratow saw rapid recovery follow in two cases after the use of these pills.

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## LEADING ARTICLE.

### PEROXIDE OF HYDROGEN IN THE TREATMENT OF DIPHTHERIA.

The success which followed the use of peroxide of hydrogen as a solvent and antiseptic in the treatment of ulcers and suppurating cavities soon suggested its employment in diphtheria. When we reflect that this substance was discovered in 1818 and that it has many times been advocated by experienced observers, it seems strange that its value was not earlier appreciated. During the past five years, however, it has taken a prominent place among antiseptic and germicidal remedies, and from the present expression of medical opinion it is certain that its usefulness will be greatly extended.

The evident advantage of peroxide of hydrogen over all other substances having the power of destroying disease-germs is its almost entire harmlessness and the readiness with which it can be employed in the various cavities of the body, as well as externally. Its efficacy being due to the potency of the nascent oxygen liberated when it is brought in contact with organic matter, it more thoroughly and safely reaches the substances we wish to destroy than any other agent of its class.

While there are some expressions of doubt of the ability of this substance as a germicide, there is, on the other hand, no question that it is in this respect one of the most powerful agents known to the bacteriologist. When it is remembered that the medicinal peroxide of hydrogen should be of fifteen volumes strength and that but few specimens in the market are of over five, it is not strange that the results obtained from its use have not been universally satisfactory. Surely no more can be expected of this substance if in too weak solution than of the now popular bichloride under the same circumstance. Regarding the proof of its germicidal power, we would refer to the experiments of Miguel who found, after a long series of carefully conducted observations

that only two other substances are more powerful germicides than this; the two being the biniodide of mercury and the same salt of silver. He thus accords to the peroxide of hydrogen greater germicidal strength than that possessed by bichloride of mercury. These researches have been repeatedly confirmed, and it has even been shown that it is positively destructive to spores, the most difficult of organic matter to destroy. Gifford found that a contact of forty-five seconds was sufficient to kill adult anthrax spores.

In the local treatment of diphtheria we have three primary indications: First, to disinfect the discharges and thus prevent the absorption of septic substances; second, to destroy the disease-germs; third, to remove the false membrane. From the present state of our knowledge concerning the properties of peroxide of hydrogen, it seems that in it we possess a substance which largely, if not entirely, fulfils these indications. Moreover, when we add that it is harmless when taken internally, easily applicable to all varieties of the disease and to all ages of the patients, certainly no local application of which we are aware so fully meets our wants.

The literature of the subject offers much valuable information respecting its utility in this grave affection. For instance, Dr. Bleyer says: "While the membrane is thin and friable, the action of this agent is thorough, quick and effective; the deposit melts down before the contact of it like sugar in water, to be reproduced in a short time and again removed until the diseased tissue beneath can be plainly seen free from this characteristic covering." Such illustrations might abundantly be given.

What is the best method of applying this substance? The answer to this question will be modified by many circumstances, such as the age and tractability of the patient, the location of the membranous deposit, etc. If the case is an adult or a child who will co-operate with the physician, the peroxide is best applied directly to the parts by a cotton wad or brush, which is far more effectual than the spray or gargling, since it mechanically removes the outer and most toxic portions of the membrane and permits of immediate penetration of the peroxide to the deeper layers or even to the mucous membrane. Such applications should be followed by similar ones of the bichloride of mercury. In case of nasal complication, it must be applied by means of insufflation or injection to the affected parts. Atomizers can now be had specially constructed to project the spray to the posterior nares, and by the same means, or by a syringe, or eye dropper the peroxide can be applied through the anterior nares. In cases of children where the resistance to the use of the probang is so violent as to render the method inadmissable or undesirable, the pharynx, as well as the nasal chambers, may be flushed by means of a common syringe, a current being projected through each nostril. Should the nose become stopped up it must be cleared by a pledget of cotton on a suitable instrument before the injection is attempted. Where the applications can be made by this method through the mouth, the current should be directed to the back of the tongue, to the larynx and to the posterior nares. Such injections are followed immediately by the formation of a frothy discharge which arises from the evolution of nascent oxygen by contact of the peroxide with the septic organic substances. In fact, the amount of the froth is a fair index of the amount of mucous membrane involved, and the disappearance or increase of the false membrane is at once indicated in the quantity of this discharge.

The evidence available certainly indicates that hydrogen peroxide will be found to be the most valuable of all substances in our armamentarium for the local treatment of diphtheria, but it is of pre-eminent importance that only absolutely reliable preparations should be used, which should be fresh, free from an excess of acid and of full fifteen volumes strength. It seems almost needless to say that the preparation should be kept in a cool place and that it rapidly deteriorates with age, and when exposed to the atmosphere.

## CORRESPONDENCE.

### PHYSICIAN AND APOTHECARY—DR. WM. BULLEYN.

TO THE EDITOR OF THE MEDICAL AND SURGICAL REPORTER:—Dr. G. Granville Faught in your issue of November 14th brings under the notice of your readers the name of Dr. Wm. Bulleyn, whose works—"The Government of Health," 1559, 800; "A Regimen Against the Pleurisy," 1562, 800; Bulleyn's Bulwark of "Defense Against all Sickness, Soreness and Wounds, that dooe Daily Assault Mankinde," 1562, 800; "A Dialogue Both Pleasant and Pietifull, wherein is a Goodlie Regimen, Against the Feuer Pestilence," 1564, 800—prove him to have been far in advance of his contemporaries.

He was born in the early part of the reign of King Henry the VIII, and was educated at Cambridge. Afterwards he went on a tour through Germany and Scotland where he pursued his favorite study, botany.

In the year 1888 the Early English Text Society published a re-print of "A Dialogue Against the Feuer Pestilence," from the edition of 1578 collated with the earlier editions of 1564 and 1575, under the editorship of Dr. Mark W. Bullen and A. H. Bullen. The work is valuable as containing the narrative of "*Mendasc*," the original of Swift's "*Splendide Mendasc*," who describes a "fletyng Island swymming about the sea, by what means I knowe not, whether occasioned by corke, wooll, &c.; it would by the winde, shifte from place to place. Sume said it was a shred of the bankes of Paradise."

From a medical point of view the dialogues between the sick merchant, "*Antonius*" and the physician Maister "*Tocrub*," and the apothecary "*Crispine*" and "*Tocrub*," are interesting.

Physician and apothecary on their way to the patient are thus described by a citizen: "Thether euen within this twoo howers I did see Maister Tocrub solmonely ridyng upon his mule, with a side goune, a greate chaine of gold about his necke, his apothicarie *Crispine*, a neighboure's childe borne hereby in Barbarie, and his little lackey, a proper young applesquire called *Pandarus*, whiche carrieth the keye of his chamber with hym. These are all gone in at the gates to that noble Italian."

The physician directs the attendants to "Drawe the fountaines, open the luket of the windowe, set sallowes about the bed besprinkled with vinegar and rose water. Take off that hot mantle; let his head and shoulders be bolstered up."

"*Antonius.* To what persones I praie you, doeth the pestilence come." "*Medicus.* Moste chiefly to theim under the place infected, then to sluttishe, beastly people, that keepe their houses and lodyngs uncleane, their meate, drinke, and clothyng moste noysome, their laboure and traudile immoderate; or to theim which lacke provident wisdome to presente the same by good diete, ayre, medicine, &c." * * * * When there doth come a "sodaine alteration or change in the qualitie of water, * * * * * * or when strong windes doe carrie pestilent fume or vapours from stinkyng places to the cleane partes, as bodies dead of the plaugare unburned. * * * * * This is a dispersed pestilence by the inspiration of the ayre."

I am Sir, Yours Truly,

GEORGE A. FOY, F. R. C. S. I.

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### PROMISCUOUS SPAYING OF WOMEN.

EDITOR OF THE MEDICAL AND SURGICAL REPORTER:—In the issue of the REPORTER for December 12th, 1891, Dr. Noble criticises my article on the removal of the ovaries of women. If the Doctor had read the article a little more carefully, he might have observed that I referred to "a certain class of ambitious young surgeons, each striving to count the greatest number of abdominal sections." This, it is needless to say, does not include "the worthy successors and followers of McDowell, Atlee, Sims, Wells, Keith, etc."

My object in bringing the subject to the attention of the profession, was not to make baseless charges against respectable gynæcologists, as my critic would have it, but to prevent, if possible, women from being unnecessarily mutilated by would-be operators. The fashionable gynæcologist would no doubt use more elegant terms than unsexed or spaying for castration of the female, but to the general profession these terms seem to be well understood and wonderfully expressive. Only a few days ago, a woman, the mother of four children, applied to me to have the ovaries removed, that she might have no more children. I tried to dissuade her from her purpose, but she seemed determined to accomplish her object, and informed me that she knew of several women who had gone through the operation, and that she expected she would have no diffi-

culty as she was prepared to pay liberally for it.

This, you will observe, is another side of the same subject, and shows conclusively, at least to me, that there are certain parties who follow the profession of "The promiscuous spaying of women."

Very respectfully, yours,

WM. C. TODD.

## BOOK REVIEWS.

THE SUPREME PASSIONS OF MAN. By PAUL PAQUIN, Late Professor of Comparative Medicine, and Director of the Bacteriological Laboratory, Missouri State University; Member of the American Public Health Association; the American Medical Association; Editor "Bacteriological World," Etc., Etc. Published by The Little Blue Book Company, Battle Creek, Mich., 1891.

This little book is one of a series of publications, by the Little Blue Book Company, which is intended to instruct the masses regarding various scientific subjects, and these subjects are presented in plain and simple language entirely suitable to the class of readers for whom the series is intended. The present volume is a freely expressed talk upon science, religion, morality and medicine, especially as they have to do with the *supreme passions* of the race. The author found it necessary, in accord with his views of the existing moral state of society, to reveal to the public eye the most common of social vices, and to his credit we will say that in general this has been done with considerable tact and delicacy of expression. The intent of the author is to prove that the passions of man are directly due to pathological nutrition, the results of wrong methods of living, eating and drinking, and that religion alone is powerless to cope with these passions. He shows how science and religion together could make the world a better place to live in, and demonstrates logically how food is the primary cause of racial characteristics, and of the development of the unnatural passions. A chapter is devoted to his theory of the causation of alcoholism, morphism, nicotism, etc., and is well worth the reading. While we cannot agree with some of the views expressed, the book as a whole contains many plain truths, and is a strong argument for better and more careful methods of living. It may be possible that it will do good to a certain class of intelligent readers, but it is certainly not a book to be carelessly read and condemned because it speaks plainly and truthfully of frightfully common human vices, and for the same reason it is possible for such knowledge to do some harm to pure, innocent minds. It is certainly one of the most vexing questions of to-day to decide just how the public generally should be made acquainted with such scientific truths as are treated of by the author of this book. We would heartily recommend its perusal to the profession as a popularly arranged contribution to sociological literature; and some parts of it will be found interesting because of ingenious theories respecting the growth of the passions. It is one of the books which are the outcome of the life-work of the author, and one may read in every page the effects of the writer's work in bacteriology and microscopic anatomy, just as the author of "Natural Law in the Spiritual World" combined in his book the results of his theological and scientific occupations.

A TEXT-BOOK OF PHYSIOLOGY. By M. FOSTER, M. D., LL. D., F. R. S., Professor of Physiology in the University of Cambridge, England. Fourth American from the fifth English edition, thoroughly revised. Philadelphia: Lea Brothers & Co. Octavo 1072 pages, 282 engravings. Cloth, $4.50; Leather, $5.50.

The appearance of another edition of Foster's Physiology again reminds us of the continued popularity of this most excellent work. There can be no doubt that this text-book not only continues to lead all others in the English language, but that this last edition is superior to its predecessors. It is evident that the author has devoted a considerable amount of time and labor in its preparation; nearly every page bearing evidences of careful revision. Although the work of the American Editor in former editions has been by the author largely adopted in a modified form in this revision, much was still left for the former to render the work fully adapted to the wants of our American students, so that the American edition will undoubtedly continue to supply the market on this side of the Atlantic. The work has been published in the characteristic creditable style of the Lea's, and owing to its enormous sale, is offered at an extremely low price.

PHOTOGRAPHS OF THE BACILLUS LA GRIPPE were presented to the Association Francaise pour l'Avancement des Sciences by M. Teissier, of Lyons, and mentioned in *Le Progres Médical* of October 3d. This culture and inoculations with it are very peculiar and interesting. It produces all the various symptoms of la grippe and even pus.

# PERISCOPE.

## THERAPEUTICS.

### THE TREATMENT OF HÆMOPTYSIS.

Professor H. Nothnagel, publishes in a Vienna medical journal an interesting paper on the treatment of hæmoptysis. The first thing, he says, is absolute rest. If the loss of blood is at all serious, the patient must not utter a sound; if it is necessary he should speak, he must only whisper, or better still, write down everything he wants to communicate. He must not be allowed to see visitors, and the sick-room must be kept at an even temperature. The patient must take nothing warm, nor anything likely to excite or irritate. The best food for the first two days is cold milk. Regular diet may then be resumed gradually, but all food which might increase the action of the heart must be avoided in future. Formerly an opinion prevailed that the patient should be allowed to cough, the retention of the blood being supposed to be hurtful, as it was believed that tuberculosis was a consequence of hæmoptysis, but this opinion is quite erroneous. On the contrary, one of the first indications is to suppress all inclination to cough as much as possible, for which purpose morphia is the best remedy. Should the hæmoptysis not cease, other remedies must be applied. The author first mentions those remedies which ought to be eschewed, and the use of which is occasionally a physiological error. The first to be banished is perchloride of iron, the action of which on the blood is to cause it to coagulate and to form a thrombus. In the form of inhalation it would be simply useless but for the great danger in allowing a patient suffering from hæmoptysis to draw a deeper breath than absolutely necessary for respiration. The liquor ferri, if administered internally, is, according to some, not absorbed at all, but, even if it be so, it would only tend to increase the hæmoptysis. The same may be said of tannic acid and of alum, which contract the blood-vessels only when diluted to ½ per cent., and are consequently useless for hæmostatic purposes as well as for inhalation. The author dispenses altogether with inhalation in hæmoptysis. The only two hæmostatic remedies he recommends as useful are ergotine and acetate of lead; the first may be used internally and in hypodermic injections, the latter may be given in conjunction with opium. Another remedy which he mentions, but of which he has himself no experience, is hydrastis canadensis. A few years ago hypodermic injections of atropine were recommended, and Prof. Nothnagel has occasionally seen them effective. No objection can be raised to half a teaspoonful of common salt when no other remedy is at hand. Hæmorrhage from the lungs is certainly sometimes arrested by its use, but the author is not quite sure if the success is *post hoc or propter hoc.* Nor is he certain whether, as supposed by some, a reflex irritation of the pulmonary vessels takes place. This theory is certainly physiologically feasible, as recent experiments have shown that sensory excitement in some parts causes the blood-vessels in other parts to contract. An application of ice, for instance, to the abdomen causes anæmia of the mucous membrane of the larynx. A very common remedy is the application of cold; but the ice-bag is, according to the author, of very doubtful value, as it is impossible to assume that the cold acts directly on the bleeding surface, for we do not know to what depth it penetrates. If the cold does act hæmostatically, the effect must be due to irritation of the skin. Professor Nothnagel warns us, however, that in some people the application of cold to the thorax causes cough, which is far more dangerous than the doubtful contraction of the blood-vessels can be useful. An extreme and heroic remedy is venesection. It is a well-known fact that wounded soldiers faint from loss of blood, when the hæmorrhage immediately stops, and a similar observation has been made in metrorrhagia and hæmoptysis.—*Lancet.*

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### HYPODERMIC INJECTIONS OF CORROSIVE SUBLIMATE IN DIPHTHERIA AND SCARLATINA.

Dr. J. Jacontini (*Morgagni*, 1890) administered by injections 1 centigramme of corrosive sublimate in eight or nine days during an epidemic of scarlatina. The fever was reduced and at the same time the manifestations in the throat were modified. Encouraged by these results the author used this treatment in two cases of diphtheria with the satisfaction of obtaining a rapid attenuation of the morbid phenomena and followed by cure.

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### MOUTHWASH FOR CARIOUS TEETH.

A mouthwash said to prevent dental caries is as follows: tannin 5 grammes, tincture of iodine and tincture of myrrh, of each

2.5 gramme; potassium iodide, 1 gramme; rose water, 180 gramme. The mouth is rinsed every morning with one teaspoonful to a glass of warm water.—*Bull. de Therapeut.*, 1891, cxx, p. viii.

### OSMIC ACID IN GOITRE.

Dr. S. Auerbach relates the case of a young woman of 25, suffering from goitre (the variety and dimensions not stated), in which he resorted to a "combined method" of treatment, including, *a*, a parenchymatous injection of a solution of osmic acid (1 grain to 2 drachms of distilled water), a syringeful once daily or every other day; *b*, local massage, for 15 minutes, once daily, and, *c*, the internal administration of iodide of potassium. By the end of three weeks all subjective symptoms disappeared, while the tumor was found to have greatly decreased in bulk (was half the size compared with the period before the treatment). Unfortunately, the woman was subsequently lost from sight.—*I etopis Khirurgitcheskaho Obshtchestva v Moskve*, No. 6, 1890, p. 505.

### QUININE POISONING.

Dr. A. Erlenmeyer reports in the *Centralblatt für Nervenheilkunde* a case of poisoning with this drug which is of some interest. The author had previously observed abolition of the reflexes in several patients who were taking large doses of quinine, but in the case under consideration the symptoms were those of an intense reflex irritability. The patient, aged forty-two years, had taken at one dose a gramme of quinine (about fifteen grains), and on the following day two grammes in divided doses. Examination of the reflexes at this time, by tapping and the other tests, brought on general convulsions, with violent contractions of the arms and the whole body. Leaving off the medication for twenty-four hours would cause a disappearance of the nervous excitability.

### TREATMENT OF PNEUMONIA IN DIABETICS.

Dr. Merklen (*Gazzetta degli Ospitali*, No. 56, 1891) regards pneumonia as one of the most dangerous complications of diabetes. It appears in diabetes without any initial chill, pains or dyspnœa; sometimes its presence is marked by intense dyspnœa, due to congestion, which may become so severe as to kill the patient in one to two days—the fulminant diabetic pneumonia of Bouchardat. It may terminate in pulmonary abscess or gangrene, yet all cases are by no means fatal. The writer narrates a case where the sugar disappeared from the urine at the beginning of the disease, to reappear during convalescence. The same was true of the polyuria, hence in such cases the reappearing of the polyuria and sugar in the urine are favorable signs. In his case there was no albuminuria. The writer prescribed caffein, 1 gramme (15 grains) a day hypodermatically, as a diuretic and heart tonic; two or three quarts of milk daily, and 1½ grammes (22 grains) of the sulphate of quinine, together with revulsion to the chest.

### CURES FOR DRUNKENNESS.

There appears to be some excitement in Illinois at present over the gold cure for drunkenness. Chloride of gold is said to be the remedy, and the *Western Druggist* says there is little new about that, for a Dr. Gray, of La Porte, Indiana, practices the following method of cure regularly. When he receives a patient he sets in his room a bottle containing a pint of good whiskey, instructing the patient that he can take all he wishes. The doctor immediately commences and gives him four hypodermic injections each day, each containing one-tenth of a grain of the chloride of gold and sodium, and one-fortieth of a grain of nitrate of strychnine, and gives a mixture to be taken by the mouth containing the same with some atropine. The formula for the mixture is:

℞

| | |
|---|---|
| Sodio-auric chloride | gr. xij. |
| Ammonium chloride | gr. vj. |
| Strychnine nitrate | gr. j. |
| Atropine | gr. ¼. |
| Fl. ext. cinchona compound | ʒ iij. |
| Fl. ext. coca | ʒ j. |
| Glycerin | ʒ j. |
| Water | ʒ j. |

Mix, and take a teaspoonful every two hours when awake.

He sees the patients four times a day and rapidly increases the gold and strychnine until the symptoms show that they are getting all they will bear. The first day the patient drinks pretty heavily of the whisky in his room. The second day he begins to lose his desire for it. By the evening of the third day or the morning of the fourth he is totally sick of it, and will not take any more. The treatment is carried on from three to six weeks. It seems to be a great success. We are frequently asked what Haines' golden specific is. A formula for producing a powder said to resemble this preparation, was contributed to the *Druggists' Circular* some time ago, and is as follows:—

℞ Bark of bayberry root.....parts xvj.
Ginger..... " viij.
Capsicum..... " j.
Reduce to a fine powder, and mix thoroughly.

—*Chem. and Drug.*

## TREATMENT OF URÆMIA.

Prof. Tissier (*Gazzetta degli Ospipitali*, No. 25, 1891), recommends:

1. Lavage of the stomach.

2. Inhalations of oxygen.

3. When the vomiting threatens to interfere with the nourishment of the patient, one to two drops of tincture of iodine in a spoonful of water are indicated. Creasote and menthol have also been successfully used. Lecorche and Telamon have succeeded in arresting the incoercible vomiting by lactic acid:

℞ Acid lactic.....mxv–xxx.
Syrup menthæ pip.....fʒ j.
Aquæ destillat.....fʒ iij.

Bouchard advises rigid intestinal antisepsis.

4. For the treatment of the cerebral and nervous symptoms he advises:

For the eclampsia, chloroform by inhalation, chloral, the bromides—preferably the sodium bromide, bromide of potash being contra-indicated on account of the potash which it contains—paraldehyde, opium and its derivatives, administered with caution on account of the impermeability of the kidneys and their tendency to accumulate.

Rosenstein and Rossbach use the nitrate of sodium:

℞ Sodii nitrat.....gr. xxx.
Syrup cortic. aurantior.....fʒ j.
Aquæ.....fʒ iij.
Two to three teaspoonfuls daily.

Labaure, Lagrave and Huchard recommend amyl nitrate, which, however, is contra-indicated when there are vascular changes present.

5. In uræmic asthma tincture of guebracho or aspidospermine are to be recommended. Lecorche and Talamon regard venesection and morphine as the true remedies in this stage. Intra-venous injections of sodium salts are useful. If the heart be weak with dyspnœa, then use such heart tonics as caffeine, adonidine, digitalis and camphor.

## THE TREATMENT OF SENILE GANGRENE.

In a recent issue of the *Deutsche Medicinische Wochenschrift*, Prof. Haidenhain presents his views on this subject, which are based on a careful study of twenty-five cases of senile gangrene of the lower extremity, the majority of which occurred in diabetics. It is a well-known fact that this form of gangrene is characterized by especial severity, so that the author's rules for treatment are worthy of careful consideration. He advises that as long as the gangrene is confined to one or two toes we should abstain from surgical intervention, and wait for a line of demarkation to form. Local antiseptic measures and elevation of the limb are all that is required, and we are especially warned against the detachment of the gangrenous portions with the scissors and forceps, which tends to increase the inflammation. If the gangrene spreads to the dorsum or sole of the foot, we should adopt Hutchinson's recommendation and amputate at the thigh, making as small skin flaps as possible. An extensive experience has shown that amputation below the knee in these cases is apt to be followed by gangrene of the flaps, which, if it does not lead to a fatal termination, renders a second operation necessary. If high amputation is deferred until the development of fever and suppuration the prognosis becomes the more unfavorable. While it is true that a successful result has sometimes been obtained by amputating below the knee, the weight of testimony is decidedly in favor of the high operation.

## ANTIPYRIN IN THE TREATMENT OF CHOREA.

Leroux (*La Semaine Médicale*, August 12, 1891) obtained favorable results in forty-one of sixty cases of chorea treated with antipyrin. In the favorable cases, the disease terminated on an average at the end of forty-five days—the usual duration of chorea being sixty-six days. In nineteen cases, the results were not favorable, either because the disease proved refractory to antipyrine or was prolonged as post-choreic tic, or because the treatment was pursued irregularly, or was suspended on account of an intercurrent affection or of an intolerance of the remedy. Recurrences and relapses were, however, frequent, notwithstanding the continuance of the treatment. Forty-five grains (daily) constituted the minimum dose from which favorable results were obtained. In some instances, it was necessary to administer from sixty to seventy-five, and even ninety grains. The treatment was begun with from fifteen to thirty grains; for children of from eight to ten years, the dose was speedily increased to from sixty to seventy-five grains; for children of from ten to twelve, to from seventy-five to ninety grains. Some cases yielded at

once to doses of from forty-five to sixty grains; but if at the end of from eight to ten days there was no change, the dose was increased in accordance with the age of the child. If, finally, at the end of a month doses of from seventy-five to ninety grains brought about no notable amelioration, no more was hoped for from its administration. Notwithstanding the prolonged administration of large doses of antipyrin, not a single grave accident occurred.

### TUBERCULIN IN LARYNGEAL PHTHISIS.

Dr. Struebing (*Deutsche Med. Wochen.*, October 8th, 1891) records the cure of a case of laryngeal tuberculosis brought about by tuberculin. There was in the case well-marked evidence of pulmonary phthisis, and the treatment is reported to have brought about an improvement in the condition of the lungs. On examination of the larynx the left vocal cord was seen to be occupied by an ulcer of considerable size, around which was much swelling and redness of the mucous membrane. The patient was extremely hoarse. After the first injection there was evidence of local reaction—swelling and injection of the laryngeal mucous membrane, and subjectively, increased hoarseness and pain in larynx, especially on swallowing, with slightly marked symptoms of stenosis. After the fourth injection no further reaction was observed. Rise of temperature was noted only after the first few injections, and then it was slight. When about nine had been given the ulcer appeared to have a cleaner look; later, improvement in this direction was undoubted; the edges, moreover, were much less prominent, and presently became obliterated, the floor of the ulcer passing insensibly into the healthy tissue around. It now became gradually smaller, and was no longer visible after the forty-third injection; this consisted of 0.1 g. tuberculin. The entire amount used up to the date of cure was 1,573 g.—*Brit. Med. Jour.*

### LOCAL ANÆSTHESIA PRODUCED BY INJECTION OF WATER.

Dr. C. L. Schleich has made experiments of himself and his assistants, which demonstrate that the hypodermatic injection of simple sterilized water produces local anæsthesia of several minutes' duration. The anæsthetic area becomes the seat of a white œdema similar to that produced by the sting of a mosquito, the extent of which depends upon the quantity of water injected. The technique of the procedure differs in no respect from the hypodermatic injection or medicated solutions; the syringe and skin are disinfected. The pain produced is no greater than that resulting from the injection of cocaine, depending upon the sensitiveness of the part, and may be almost entirely prevented by spraying the parts with ether at the time of injection. The needle is inserted slowly and parallel with the cutaneous surface. The anæsthesia is so complete that incisions may be made into the skin without the slightest pain.—*Deut. Medizin-Zeitung*, No. 66, 1891.

### YEAST IN ENTERIC FEVER.

M. de Bavay's paper read before the Melbourne and South Australian Branch on the action of yeast on the typhoid bacillus contains an account of experiments in the intestinal canal of the human subject, he believes that he has been able to obtain a set of conditions under which the development of the typhoid organism is materially interfered with, whilst such poison as it does secrete is so utilized by absorption from the alimentary canal as to confer an immunity against the action of the more virulent poison. It will be remembered that in 1887 Dr. J. B. Buist brought forward a method of yeast inoculation against the action of small-pox; but his experiments at the time were not convincing, and, though undoubtedly exceedingly interesting, they were not, we believe, attended with any practical result. We shall now await with interest medical reports on the results of M. de Bavay's treatment, as only actual confirmation of the theory here put forth can enable any definite opinion to be pronounced. Those who heard the paper read at the meeting of the Melbourne Branch were apparently considerably impressed with a sense of its importance, and certainly both the argument and the work seem to have carefully carried out.—*Brit. Med. Jour.*

## MEDICINE.

### SPONTANEOUS SHEDDING OF THE NAILS IN DIABETIC PATIENTS.

Prof. Auché *Rivista Clinica e Therapeutica*, No. 4, 1891) communicates the results of his studying the development of this phenomenon in diabetic patients. First a hæmorrhage takes place into the tissue beneath the nail which, according to its amount, detaches the nail more or less extensively from

its bed. If the hæmorrhage be but slight, there appears a small and reddish film; if more abundant, the nail is raised from its bed, remaining attached only at the extreme lateral borders, until a new nail forms when the old nail is cast off. The writer is inclined to regard the spontaneous hæmorrhage as due to lesions of the peripheral nerves. His conclusions are as follows:

1. Diabetes mellitus, like tabes dorsalis, hysteria and various other affections, may, and often does, cause spontaneous shedding of the nails of the hands and more frequently those of the feet.

2. Shedding may take place in two manners. In certain cases the hæmorrhage and detachment occur without any preceding symptoms or disorder, when the diagnosis between syphilis and locomotor ataxia would be without the aid of concomitant symptoms, extremely difficult. In other cases subungual hæmorrhage may precede detachment. In such cases, the mechanism is similar to that observed in certain tabic patients.

3. These hæmorrhages are not only due to changes in the vessel walls, but also, in some cases, to lesions of the nerves found in the fingers.

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## MENIERE'S VERTIGO AND THE SEMICIRCULAR CANALS.

The experiments of Flourens, which seemed to attribute to the semicircular canals the *role* of maintaining the equilibrium of the body, have been controverted by others to such an extent as to make it appear doubtful whether that part of the labyrinth is the seat of the lesion which determines the so-called vertigo of Ménière. The peculiar character of the vomiting, the fact that the latter symptom may occur suddenly without nausea, after irritation of the membrana tympani, the intimate connections between the pneumogastric and the auditory nerve at their origin, renders it more probable that the vertigo and cardiac symptoms are due to a reflex action in the pneumogastric dependent upon a lesion in some portion of the auditory nerve. The term Ménière's disease serves more frequently to mark ignorance of the lesion which occasions a series of symptoms often analogous but which are under the influence of very different causes. —Sir Wm. B. Dalby, *Brit. Med. Journal*, and *Annales des Maladies de l' Oreille*, etc., vol. xvii.

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**Koch is Still at Work on Tuberculin, and hopes to make it gradually less and less deadly.**

## EXAMINATION OF THE EYES OF THE INSANE.

M. Roget (of Lyons) states that there exists in the greater part of the general paralytic a characteristic rigidity of the pupil. Besides excavation of the papilla, quite frequent in the normal state, should be regarded as the rule in those hereditarily predisposed, and in the insane who exhibit evidences of suicide. Finally, idiots and imbeciles, in respect to visual function, may be classed in two categories: The hypermetropic idiots are those whose infirmity dates back to uterine life; on the contrary, emmetropic and myopic idiots have become demented since infancy.

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## ARTIFICIAL NEURASTHENIA.

Dr. Von Pelizarva (*Deutsche Med. Woch.*) describes a condition which he has observed to come on in a patient undergoing the water treatment at mineral springs and to which he has applied the name of artificial neurasthenia. This condition has frequently been described as bath or spring fever, but the author of the present article says that it is undoubtedly a form of nervous disturbance resulting from the indiscriminate use of the bath and drinking of the mineral waters.

It is well known that there is a great difference in individual ability to react from certain shocks. At one time reaction from a cold bath would be prompt, at another there will be distinct loss of control of the will, shrinking and so forth, followed by depression and weakness. When such results obtain and the baths are persisted in the process will undoubtedly cause lessening of the resisting power of the nervous system. When it is remembered how great is the number of people ordered to the baths by physicians and how many go on their own account and take a regular course of treatment, in spite of the discomfort it may cause, it is not to be wondered at that patients return with neurasthenia or an exhaustive neurosis. The condition is soon established and it is for this reason that the author urges upon medical advisers sending patients to the springs, and also upon the physicians attending there, greater care in the selection of cases destined to undergo regular treatment. Due to the lack of the necessary foresight in this regard, Carlsbad, and Kissengen are prominent sites for the promotion of this form of nervous artificial neurasthenia.

## SYPHILITIC DISEASES OF THE SPINAL COLUMN.

Dr. Jasinski (*Archiv. für Derm. und Syphilis*, No. 3, 1891) maintains (1) that syphilis of the spinal column occurs under the forms of periostitis, ostitis gummosa, caries, exostosis, and necrosis; and (2) that it is a relatively very rare affection when diagnosis is established beyond a doubt.

A number of personal cases are reported, one of perispondylitis syphilitica; one of gummous inflammation of the periosteum and bodies of the cervical vertebræ, which was cured by immobilization, with a plaster-of-Paris dressing, and inunctions combined with large doses of iodide.

Several instances of spinal affection in children are given and the literature of the subject is reviewed at some length.

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## THE ORIGIN OF EFFUSIONS.

Dr. G. Pisenti (*Riforma Medica*, June 12th, 1891) describes an experiment which serves to explain several points as to the origin of effusions. The method is simple, and one which can be easily demonstrated in the course of a lecture on pathology. The only preparation necessary is the following: A rabbit or guinea-pig is fixed in the retention apparatus, anæsthesia being produced either by ether or chloroform. An incision is then made along the linea alba about 4 inches long, so as fully to expose the abdominal cavity. The intestines are then raised and turned over to the left, thus exposing the portal vein, into which a cannula is tied. This cannula is next placed in communication with a reservoir containing either pure defibrinated blood, a mixture of blood and saline solution, or simply saline solutions (0.75 per cent.) The liquor should be kept warm, and the pressure measured by means of a manometer. The costal arch is then raised so as to expose the upper surface of the liver, and the artificial circulation is commenced under a pressure of about 2 mm. of mercury. In a few moments pale areas appear on the surface of the liver, which continue to increase as long as the circulation is maintained. If pressure be then raised a curious phenomenon is observed: numerous small drops of liquid exude through Glisson's capsule, and after a time run together, so that the surface of the liver becomes bathed in liquid. The rapidity of the exudation depends upon the pressure at which the artificial circulation is maintained. (1) There has thus been produced a true œdema from stasis, for supplying more liquid than can be removed by the efferent vessels, all the effects of a block in the circulation are reproduced, this effect increasing with any increase in pressure. (2) The same method can be used to demonstrate the production of exudation due to hydræmic plethora; by introducing simple saline solution all the effects of a hypo-albuminous condition of the blood can be obtained. In this case the effect on a single organ, the liver, will be similar to that produced on the entire body by the intravenous injection of large quantities of saline solution. It serves well to explain the origin of the acites so often seen associated with a watery condition of the blood. (3) It is well known that some tissues are more prone to œdema than others, and this is also illustrated by the above experiment, for of all organs that might be used the liver is that in which the phenomena can be best seen. It would appear, then, that the walls of its vessels are less resistant than those of other organs to the passage of liquids. (4) Lastly, from the rapidity with which exudation commences, it may be concluded that this can happen without any alteration of the vessel walls themselves, and this in opposition to the view held by some that exudation cannot take place without initial vascular lesions. To summarize, this experiment of Dr. Pisenti demonstrates (*a*) that increase of intravascular pressure plays an active part in the production of exudations (exudation of stasis); (*b*) that exudation may arise from alteration in the consistence of the blood (exudation from hydræmia); (*c*) that the histological constitution of the vascular walls varies from tissue to tissue, and from organ to organ; (*d*) that exudation may take place independently of any alteration in the walls of the vessels.—*Brit. Med. Jour.*

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## GOITRE—ITS PATHOLOGY, DIAGNOSIS AND TREATMENT.

Berry (*British Medical Journal*, June 13, 20 and 27, 1891) has made an extremely clear and valuable contribution to the subject of goitre.

He makes five varieties: (1) parenchymatous, (2) cystic, (3) fibro-adenomatous, (4) malignant, and (5) exophthalmic. All these varieties, except the last, which stands alone, clinically and structurally, run very much into each other, so that mixed forms are common.

From an extensive study of the probable causes of goitre, Berry concludes that its co-

incidence with limestone and calcareous sandstone districts everywhere in England is so marked that its appearance as an endemic disease in non-calcareous regions is doubtful. All attempts to produce goitre artificially have failed, from the experiments of St. Lager to those of the present day. Animals drinking solutions of the different forms of salts found in water from these regions, have never shown any sign of goitre, although goitre is common in lower animals in goitrous districts.

Yet the fact that goitre can be produced by water has been proved accidentally from human experimentation. For example, in a regiment of young soldiers, quartered in a goitrous village, there developed, in a large proportion of the men, goitres in a few months or even weeks. Again, a town has has received a new water supply, and shortly afterward goitre has broken out in a large number of the inhabitants. Conversely, a village afflicted with goitre has been relieved of that disease by changing its water supply.

There are "goitre-wells" on the continent, to which young men, who wish to be exempt from military service, resort; after drinking this water for a few weeks, they obtain goitres sufficiently large for them to obtain their wish.

Mere hardness in the water does not cause goitre. Berry believes that there is a definite relation between goitre and some poison in the soil, which is carried by drinking water. This may be some mineral ingredient, possibly a salt of some alkali or alkaline earth. From personal experiment he believes that it is not a salt of lime, magnesia or iron. Want of air and sunshine, climatic and atmospheric conditions, heredity, habits and intermarriage, have apparently no share in the causation of goitre.

The effect of goitre on the duration of life is small. In some cases pressure on the trachea causes death. Again, if bronchitis or some similar disease intervenes, the patient has a much smaller chance of recovery.

In regard to the treatment of goitre, the author believes that injections of various substances to excite sufficient inflammation to obliterate the vesicles of the gland, or to have some solvent action on the colloid contents, is not devoid of danger. Iodine is far preferable to every other substance; yet its injection has been followed in a number of cases by death. Internal administration of remedies is briefly discussed and dismissed. The use of setons was wisely abandoned long ago.

A noteworthy series of cases has been reported by Rydygier, of Cracow, in which ligature of the superior and inferior thyroid arteries on both sides has been performed. In sixteen cases the results were excellent, although the operation is a difficult one, and the patients have not been watched for sufficient time. Cystic or fibro-adenomatous goitres are less likely to be benefited by such ligation. Division and resection of the thyroid isthmus have been less successful; the operations have been followed by death in some cases, or the dyspnœa, for relief of which the operation was done, was unimproved. Total extirpation of the gland is not recommended on account of its grave dangers. Partial extirpation has been done by Berry, frequently with good results. *Mukulicz's resection*, which consists in removing the chief part of a lateral lobe, avoiding the recurrent laryngeal nerve by leaving the portion of the gland adjacent intact, has the advantage that it leaves sufficient gland tissue to prevent cachexia strumipriva, avoids hæmorrhage and injury to the recurrent laryngeal nerve, and removes the capsule of functionally useless gland tissue. There has never been a return of the goitre in the portion of gland in twenty-three cases operated on according to Mukulicz's method, nor impairment of health, although one case died of recurrent hæmorrhage and one required a tracheotomy.

In 550 cases of partial thyroidectomy only six present symptoms of cachexia strumipriva; five of these recovered and one died. In cases of cachexia strumipriva, transplantation of thyroid tissue, as done by Kocher, Horsley and Fenwick, can be tried. Pilocarpin, jaborandi and nitro-glycerin should be of service. In malignant goitre no operation but tracheotomy is advisable. Kocher has reported the results of 250 consecutive operations on goitre, with a mortality, if malignant and exophthalmic goitrous disease be eliminated, of 0.8 per cent. Cachexia strumipriva is the most important remote effect of thyroidectomy; the existence of this remarkable affection, following the operation, was drawn to the attention of the profession in 1883; its recognition had a great effect in modifying views held in regard to thyroidectomy. Berry believes it can be avoided by performing partial thyroidectomy.—*Univ. Med. Mag.*

### CLINICAL STUDY OF THE CONDITION OF THE HEART IN TYPHOID FEVER.

Dr. L. Galliard, (*Archives Générales de Médicine*) took careful notes of the anomalies in the condition of the heart during an epidemic of typhoid fever in Paris, in 1880, while he was interne under Professor Hayem in the Saint Antoine Hospital. He had delayed publishing the notes, as he had hoped to have made further investigations on the subject, but circumstances prevented him, he simply gives the clinical notes of the cases as they were taken at the time.

The first case was one of sudden death at the end of the first week of the disease. The patient was progressing favorably, the temperature 37.8° C. in the morning, and 40.2° C. in the evening, when he became delirious, and after a short time died. No cause could be found in the *post mortem* examination to account for the death.

The second case was one of collapse on the thirteenth day. There had been profuse diarrhœa, and the temperature from 39.5° C. on the eleventh day, gradually sank to 36.1° C. in the armpit, and 37.4° C. in the rectum on the thirteenth. He presented all the appearance of a cholera patient, with cold extremities, livid face, almost pulseless, and no heart sounds to be heard. Under stimulating treatment he gradually recovered.

The third and fourth were cases of non-rhythmical intermittence of the pulse, the third exhibiting the intermission only on the day of entry [the eighth of the disease]. There was a murmur [systolic?] at the apex and at the base of the heart. In the fourth case, the intermissions continued from the 8th to the 24th day. There was slight albuminuria.

The fifth was an anæmic girl, in whom rhythmical intermissions occurred after defervescence—from the 24th, and lasting three weeks. There was also systolic murmur at the apex and in the pulmonary area. In the sphygmographic tracings there occurred an occasional double pulsation. The patient had also a slight relapse.

The sixth case was at first simply asthenic, with feebleness of the apex beat, and of the heart sounds. There were intermissions on the 24th day when the fever was abating. Pneumonia ensued, and the patient died. There was myocarditis.

The seventh case had untractable diarrhœa. At the end of the third week there was feebleness of the heart and faint first sound. Later, at the apex, the first sound could scarcely be perceived while heard distinctly over the sternum. There was also inequality and irregularity in the pulse beat. The patient died suddenly about the end of the fourth week. Myocarditis and vitreous degeneration of the voluntary muscles were found.

In the eighth case there was systolic murmurs at the base and apex observed on the eighth day of the disease, disappearing on the tenth from enfeeblement, and the patient died on the twelfth. There was myocarditis.

The ninth case was somewhat similar to the eighth.

In the tenth there were anæmic murmurs that persisted after recovery and the author points out the necessity to distinguish anæmic murmurs from murmurs arising in cases of myocarditis.

The next three cases are examples of the true cardiac form of typhoid fever. There is a general resemblance in all these cases—intermissions of the heart's action coinciding with the murmurs, or following on the disappearance of the heart's sounds, and feebleness of the apex beats. Towards the end the heart's action becomes irregular, accompanied by tachycardia, and is premonitory of a fatal termination, and finally syncope, preceding death. There were also complications in the lungs, kidneys, nervous system, etc. In the three cases given myocarditis was demonstrated in each one.

The last two cases of endocarditis, the murmurs appearing in the one case on the eighth day, and persisting after recovery, and in the other case acute endocarditis was diagnosed before the symptoms of typhoid fever developed, the murmurs persisting here also after recovery.

The author concludes with a few remarks on the causes of the cardiac phenomena, pointing out that, in addition to the local mischief, affections of various nerve centres would account for some symptoms. In treatment, he strongly recommends the judicious and bold use of digitalis.

## SURGERY.

### ARTHROTOMY IN OLD LUXATIONS.

V. Vaurossy (*Wien. klin. Woch.*, 1890, No. 50). V. reports from the Innsbruck clinic nine cases of old elbow luxations, and one each of shoulder and metacarpo-phalangeal of the thumb. The elbow luxations consisted of backward dislocation of both of the forearms. Either the external or internal epicondyle, or both, as in one case,

served as barriers to reduction by being forced into the joint. The longest duration of the luxation was twenty-four months. The younger the individual and the luxation, the more favorable the prognosis. The cartilaginous covering of the articular extremities of the bones suffers less in young individuals, in case of luxations of long standing, than in olders ones.

In performing arthrotomy in these cases, the joint was opened from both sides. The author, as a result of his experience, declares that by means of arthrotomy a much better result is reached than by a most economically planned resection. Subcutaneous separation of the intra-articular bands which form in these cases the author declares to be entirely insufficient.

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## MODERN RENAL SURGERY.

Dr. A. Obalinski sums up his views regarding the treatment of severe inflammatory affections of the kidneys and their sequelæ in the following way: 1. Suppurative inflammation of the kidney and surrounding structures indicates the operation of nephrectomy in order that free exit may be given to the purulent and other inflammatory excretions, and that the focus of the diseased may be thoroughly cleansed, and further extension of the suppuration to important parts, as, for example, the thoracic and abdominal cavities and the hipjoint, be thus prevented. In most cases the single lumbar incision, as was performed by Simon, will suffice, but when there has been extensive undermining of the peritoneum the formation of a large flap, as practiced by Bardenheur, is to be preferred, as such operation permits of ready access to all extensions of the main pus-containing cavity. 2. Urethral fistulæ should always be treated by removal of the corresponding kidney, provided the surgeon can assure himself of the existence of a sound renal organ on the other side. Nephrectomy in such cases is indicated, not only on subjective grounds and when, for instance, the external flow of urine cannot be restrained by any apparatus and the patient is thus prevented from following his occupation and from enjoying a comfortable existence, but also on objective grounds, since, notwithstanding the utmost precautions, an old ureteral fistula may result in suppurative inflammation of the corresponding kidney and of the adjacent soft parts. 3. Nephrectomy performed under these last mentioned conditions offers much less favorable prospects than in cases in which there is an absence of suppuration or of cicatricial adhesions. 4. There can be no doubt that, under equally favorable conditions, the transperitoneal method can be performed more rapidly and with greater ease than the extraperitoneal method of nephrectomy, and that the progress toward recovery is more speedy after the former operation. The transperitoneal method, however, is not applicable to every case, and should be reserved for those instances in which the mischief is confined within the capsule of the kidney, the extraperitoneal method being indicated when the suppurative process has involved the perirenal structures.—*Volkmann's Sammlung Klinische Vorträge.*

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## RESECTION OF THE SKULL IN TRAUMATIC EPILEPSY.

Dr. A. Garibaldi (*Gazz. degli Ospitali*, October 4th, 1891) reports the case of a man, aged 23, who, ten years previously, had fallen from a considerable height on his head, sustaining a compound comminuted fracture of the skull in the right frontoparietal region. After this accident he became subject to epileptic attacks; these were at first partial, starting from the left leg, particularly the flexor muscles; during them the man was dazed, but did not lose consciousness. The attacks gradually became more frequent, until they occurred two or three times a week. On examination an irregular cicatrix was found on the right side of the skull directed obliquely from without inwards, from below upwards, and from behind forwards. The scar was about 8 centimetres in length, and at its middle part about 3 in breadth; at this point irregular bony prominences and depressions could be felt. On measurement the scar was found to correspond to the upper part of the prerolandic convolution and the first and second frontal convolutions. On April 29th, 1891, Dr. Garibaldi operated. He first removed the whole of the bony cicatrix, resecting with the scalpel the cranial bones around the scar, and in this way making a breach in the skull of about 4 square centimetres in extent, and exposing the dura mater over the whole area. In the anterior part of the wound a swelling rather larger than a hazel nut, and containing serous fluid, was opened. There was a little hæmorrhage from the diploë and the dura mater on breaking down some adhesions; with this exception there was no complication. The operation was performed with the strictest

antiseptic precautions. Recovery took place without interruption; the wound healed almost entirely by second intention, as the skin flap, which consisted of old cicatrical tissue, partly sloughed. At the date of the report the cicatrix was fibrous and resistant. With regard to the fits the result was only moderately satisfactory. With the exception of a slight attack, which occurred the day after the operation, there were no further seizures until May 22nd, when general convulsions occurred twice. On the following day the patient complained of cramps in the lower limb, and on the night of June 5th another attack occurred, which was followed by headache. On June 30th and again on July 5th he had attacks during the night. On July 15th one took place during the day, and other attacks occurred at the end of the same month and at the beginning of August. The patient cannot, therefore, be considered cured, and there is little hope of much further improvement as time goes on.—*Brit. Med. Jour.*

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### THE TREATMENT OF VARICOLA.

According to Dr. Landerer, the extirpation or obliteration of varicose scrotal veins is apt to be followed by relapses. In one of his cases of recurrence he obtained an excellent result by letting the patient wear a hernia truss with movable pad, according to the method of Ravoth. One and a half years after application of the truss the varix had disappeared completely, and after wearing it for a year longer it was left off, and since eight years, there has been no return of the varicocele. An equally successful result was obtained in three other cases. The truss probably acts as an artificial substitute for the valves of the veins which have either completely disappeared in the varicosities or are in a rudimentary condition. This procedure is also applicable to varices of the lower extremities. For this purpose the author makes use of an apparatus consisting of a curved spring and a pad filled with water, which is made to press directly upon the saphena vein. He has employed this truss in eighty cases with very satisfactory results. Its application is much more agreeable to the patient than bandaging, and then it is much cheaper than an elastic stocking. Under the use of the apparatus a reduction in the size of the limb has been observed, but the treatment must be regarded as palliative rather than curative.—*Deut. Medizinal-Zeitung.*

### MECHANISM OF FRACTURES IN THE DORSAL AND DORSO-LUMBAR REGION OF THE VERTEBRAL COLUMN.

In *L'Union Medicale*, July 2, 1891, Dr. J. Ménard gives the following conclusions:

(1) Indirect fractures are most common and are produced by forced flexion.

(2) There is first a sinking, then tearing, then breaking, the last often independent of the tearing.

(3) Simple sinking, constantly found in dorso-lumbar region, is not known in dorsal region.

(4) Breaking more frequent in dorsal; the tearing exists in both regions.

(5) Ordinary cause of dorso-lumbar fractures arise from falls upon the seat of lower limbs; more rarely from bodies pressing on the nape of the neck and top of back, with flexion of trunk.

(6) Dorsal fractures from falls on the nape of the neck or from flexion caused by pressure on nape of neck, and top of back—the trunk being vertical.

(7) With dorsal fractures, there are almost always fractures of the ribs, sometimes of the sternum.

(8) Compression of the cord generally caused by the posterior superior border of the inferior fragment of the body of the vertebra.

(9) The indication is to reduce and maintain reduction for a sufficient time.

(10) Trephining is seldom indicated and should be reserved for mixed fractures and crushings of the posterior arch.—*Univ. Med. Mag.*

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### AN OPERATION FOR TETANOID CONVULSIONS.

The *Centralblatt für klinische Medicin* refers to a case of Mr. T. R. Ronaldson's, recorded in the *Edinburgh Medical Journal*, in which a perfectly healthy child was attacked with tetanus on the eleventh day after birth. The birth had been a normal one, except that the child had a very thick umbilical cord. On examination, the stump was found discolored and foul-smelling. Symptoms of inflammation had not been present. Frequent washings with a corrosive-sublimate solution was carried out and everything was done to prevent a recurrence of the convulsions, but without avail. On the twenty-third day the author performed excision of the navel, with the result of the gradual diminution of the frequency of the attacks. By the end of the seventh week the convulsions had entirely disappeared

and the child was restored to perfect health. There was no micro-organisms found in the excised umbilical stump.

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## LAPAROTOMY FOR WOUNDS OF THE LIVER.

Broca (*Le Mercredi Medical*, 1891, No. 29) reports two cases of wound of the liver, each treated by surgical intervention, and each terminating fatally.

The first patient was seen six hours after the infliction of the stab wound. He exhibited the symptoms of large hæmorrhage. The wound was enlarged; the source of bleeding was found to be the liver; blood was flowing freely from the incision upon the anterior surface of this organ. An attempt to suture this wound proved futile, the threads tearing through. Thermo-cautery also failed to check the bleeding; an iodoform tampon was, however, entirely successful. An hour was consumed in the operation.

The patient perished two days later of abdominal septicæmia.

At the autopsy several other wounds were found, in some of which there had been bleeding after operation.

The second case was also a stab wound. The patient was seen four hours after the injury, and presented all the symptoms of intra-peritoneal hæmorrhage. The abdomen was opened and a non-penetrating and penetrating wound of the stomach were found. A wound three inches long was observed on the lower surface of the liver. By means of a silk suture this wound was closed and the bleeding ceased. The patient died in a few hours with symptoms of continued hæmorrhage.

At the autopsy it was found that the knife had passed completely through the liver, the wound of exit being located on the upper surface of this organ one-fifth of an inch behind the suspensory ligament. From this source sufficient blood flowed to entirely fill the pelvis.—*Amer. Jour. Med. Sci.*

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## AN IMPROVED METHOD OF GRAFTING ULCERS.

Dr. Gill in a letter to the *Lancet*, says that having had an exceptionally large number of chronic ulcers of the leg, which incapacitated the patients from work, and finally brought them into the infirmary, he tried the ordinary methods of grafting, but being disgusted with the very large number of total failures, he experienced, he undertook various experiments, and at last adopted the following plan, which he distinctly disclaims as his own, but which consists in adopting and combining the ideas of several people. The success he obtained with this method was so marked that he thinks a large number of practitioners at home and abroad (in India especially, where he found all ulcers very intractable under ordinary treatment) will welcome it. Even when the ulcer is deep, with hard thickened edges and extending all around the limb, the method applies. This is to cleanse the surface well for two or three days with boracic fomentations, and then (contrary to what he was taught) slightly abrade the granulations, just sufficient to cause oozing, and apply the graft directly to the abraded surface, where it is held in position by a small pile made of half-inch squares of green protective, four or five squares being placed one on the top of the other. A graft is thus applied to every square inch of surface. And now comes the most important thing of all, and which is an idea he received from a friend. This is to encircle the limb with a fold of carbolic gauze, which extends two or three inches above and below the ulcer, where it is attached to the sound skin by collodion. The ulcer is then thoroughly dredged with boracic powder through the gauze, and the whole is wrapped in a layer of wet boracic lint, which is kept thoroughly moist. As a rule, the dressing is not disturbed for three days, when the lint is removed, and the limb, well irrigated with boracic lotion, the grafts remaining perfectly secure under their heaps of protective, which again is kept in position by the gauze. The limb is then redusted with boracic powder, and done up in the wet lint, which is now changed daily. At the end of ten days the gauze and protective are removed, and each graft will be found as large as a sixpence, while those near the edges will have exercised a spermatic influence, and caused a rapid ingrowing of epthelium. Since adopting the above plan Dr. Gill says that he has never lost a single graft, though employed on most unfavorable surfaces—a very different result to the old way of covering the grafts with a large piece of protective which retained some exudations under it, and thus bathed the tender graft in a poisonous medium, with a result that 80 per cent. of them never "took."

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## IODINE WATER AND ARISTOL AS SURGICAL ANTISEPTICS.

Popoff speaks very highly of the antiseptic effects of irrigations with iodine water

(1 to 10,000), and consecutive powdering with aristol (pure or in a form of a 20 per cent. mixture with boracic acid) in cases of tuberculosis of joints (fungating arthritis, etc.) and bones, callous syphilitic ulcers, simple chronic ulcers, angina Ludovici, phlegmon, furunculosis, wounds of every description, etc. The iodine lotion also gives excellent results in inveterate ozæna. In addition to its powerful antiseptic properties it has a decided astringent and hæmostatic action. Under its use luxuriant and profusely bleeding granulations rapidly assume a normal appearance, cease to bleed, etc. The iodine water likewise speedily checks parenchymatous hæmorrhage from any recent wounds.

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## CONCERNING THE TIME AND CAUSE OF THE EXTENSION OF GONORRHŒA TO THE PARS POSTERIOR URETHRÆ.

After an examination of fifty cases of first infection of gonorrhœa, Dr. Ignatz Heisler, (*Archiv. für Dermatologie und Syphilis*, 1891, 5 Heft.) concludes:

1st. That posterior urethritis appears much earlier than is usually taught and accepted by the best writers.

His statistics show that in twenty per cent. of the cases it appeared in the first week, in thirty-four per cent. in the second week, and in fourteen per cent. in the third week after the appearance of the discharge.

2d. Constitutional affections, especially syphilis, have little influence in hastening the occurrence of posterior urethritis, although the affection occurs more frequently in syphilitic subjects.

3d. Occupations which necessitate long-continued exertion play an important role in expediting affections of the deep urethra.

4th. The affection is equally prevalent whether injections are used or the treatment be confined to internal medication.

5th. The musculus compressor urethræ has no power to prevent the transference of the infective agent to the deep urethra.

6th. The gonorrhœal inflammation of the anterior urethra cannot be regarded as an affection of such typical course as is asserted by the majority of authors, *i. e.*, an inflammation starting in the fossa navicularis, reaching the bulb in three weeks; then, when the acme of intensity is attained, passing over to the posterior urethra. In the great majority of the cases, this happens during the first or second week without the direct transference of the gonorrhœal pus by means of catheters or sounds.

It must therefore be looked upon, not as a complication of anterior urethritis, but as a direct continuation of it.

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## SUTURING OF NERVES.

Th. Köllker (*Deutsch Chir.*, 189, Liefg. 246, Stuttgart, Ferd Enke, 1890). The discussion of the interesting question of primary union of divided nerves, as well as the processes of degeneration and regeneration, is entered into in connection with the subject of nerve suture and operations upon nerves. The author's researches, to be published later, show, contrary to Friedländer and Krause, degeneration of all of the fibres of the peripheral nerve stumps, the latter, according to Kölliker taking no active part in the process of regeneration, but simply serving as a guide for the newly-formed nerve fibres in their passage from the central nerve stump to the periphery. Immediate contact of the severed axis cylinder may possibly lead to immediate union of the same, but there is no indubitable evidence of this having occurred. Union by formation of a small amount of new-formation tissue, with the development of nerve fibres as demonstrated by the microscope, without degeneration of the distal ends of the nerves, according to K., has occurred.

In suturing nerves, Kölliker does not employ one method to the exclusion of the rest. In cases in which the ends can be brought together only after considerable force, the direct method is indicated; in cases in which there is no tension, the indirect plan is adopted. Silkworm gut, or catgut, is employed as a suture material. In cases in which there is a deficiency to the extent of 4 ctm., due to removal of a section of the nerve, he recommends stretching the nerve to fill the gap, and subsequent suturing. In cases of a more considerable gap, Vanlair's method of tubulization, or union by means of catgut loops, is preferable to nerve transplantation. In cases in which the central end of the injured nerve cannot be found, implantation of the distal end to a neighboring nerve is recommended. This method of "neurotization" whereby the distribution to a distant part is effected through the medium of a nerve trunk not originally destined for this purpose, promises to be a valuable aid in cases otherwise hopeless.

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The Debility following Influenza is said to be greatly benefited by anacardium occidentale (cashew nut).

## GYNÆCOLOGY.

### NOTE ON THE VALUE OF IGNIPUNCTURE IN THE TREATMENT OF HYPERTROPHIED CERVIX UTERI.

Dr. Alexander Duke, writes in the *Lancet* that the length of time occupied by the usual routine treatment of a case of chronic hypertrophied cervix uteri can be considerably shortened by the judicious use of ignipuncture. The usual plans of treatment—viz., tampons of glycerine, copious syringing with very little hot water, painting cervix with Churchill's tincture of iodine, etc.,—occupy a very considerable time, which prolonged treatment (unless the patient is able and willing to pay for) "is more honored in the breach than the observance." Superficial firing by caustics or smouldering pieces of carbon held in contact with cervix by forceps is not sufficient in well-marked cases of chronic hypertrophy to obtain the desired result within a reasonable time. Having observed the good effects on enlarged tonsils by the employment of ignipuncture, he has given it a trial, and can strongly recommend it as a useful adjunct in these cases. A thermo-cautery of small size and point (Paquelin's) will be found the best for the purpose, but those who do not possess this valuable instrument can obtain equally good results with a copper rod, sharp at the point, and with solid bulb about half an inch from the top, so as to retain the heat while the necessary number of punctures are made through a wooden or celluloid cylindrical speculum. This cautery can be heated with an ordinary spirit lamp till red-hot, held in the tissues for a few seconds, while each puncture, about a quarter of an inch, is made, and then withdrawn. There should be no bleeding observable if the operation has been properly performed, such being caused by the cautery being either too hot or too cold. His usual practice is to blow a little boric acid (with his vaginal insufflator) over the punctured surface, and make no examination for about a week, when the operation can be repeated if necessary. He has also found ignipuncture of great value in lacerations of the cervix when hardly bad enough to demand Emmet's operation. Little pain, if any, is produced unless the operator is unwise enough to allow the patient to observe the preliminaries.

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A Faculty of Medicine is about to be established in Constantinople.

### REMARKS ON A SERIES OF ONE HUNDRED LAPAROTOMIES.

Ten years ago to-day, Dr. Joseph Taber Johnson says, he performed his first laparotomy on a lady completely broken down, mentally and physically, on account of menstrual epilepsy. When he heard from her last, she was alive and doing well—not a "brilliant cure in sixteen days," but so much improved as to induce her to write that she and her family were very glad the operation had been done.

His next case occurred two years later; she also recovered. His next three cases died. None of them suffered from the four principal causes of death following laparotomy—shock, hæmorrhage, peritonitis, or sepsis. But still, he began at once to study over again his abdominal surgery, and in the hope of doing better work in future, took lessons from the best operators across the ocean, as well as in our own country. He saw Tait perform twenty-three abdominal sections. He studied the methods of Keith, in Edinburgh, Bantock and Thornton, in London. He had previously seen Sir Spencer Wells operate.

He saw operations under clouds of carbolic spray, and without spray. He saw every detail and variety of antiseptics used, and other operations, equally, if not more successful, where only "surgical cleanliness" was observed. He made many trips to New York, Philadelphia, and Baltimore upon invitation and toleration to study the methods of our most successful abdominal surgeons, in all witnessing and assisting, where he could, in at least two hundred laparotomies for a great variety of conditions.

After this increase of experience with men and methods, he had a run of 25 ovarian operations without a death; the twenty-sixth case died. Another run of fourteen cases without a death; the fifteenth died of tetanus the fourteenth day after the operation. Another run of thirty-three cases without a death—making a new series of seventy-three ovarian operations, with seventy-one recoveries and two deaths. The first series of five cases had three deaths.

In this report of 100 consecutive laparotomies, he only proposes to discuss, briefly, the value of surgical interference in some of the different groups of cases embraced in the accompanying table.

Laparotomy was done for the—

| | | | |
|---|---|---|---|
| Removal of uterine appendages, . . . . . | 42 | times with | 3 deaths. |
| Ovarian tumors, . . . | 37 | " | 2 " |

| | | | | |
|---|---|---|---|---|
| Uterine fibroids, supra-vaginal hysterectomy, . . | 12 | " | 4 | " |
| Cæsarean section, . . . | 1 | " | 1 | " |
| Hydro-nephrosis (74 lbs), | 1 | " | 1 | " |
| Exploratory laparotomies, | 3 | " | 0 | " |
| Universal cancer, . . . | 1 | " | 1 | " |
| Ruptured tubal pregnancy (supposed), . . . . | 1 | " | 1 | " |
| Chronic peritonitis, . . . | 1 | " | 0 | " |
| Laparotomy for abdominal dropsy, . . . . . | 1 | " | 0 | " |
| | 100 | " | 13 | " |

### HYDRASTININ IN METRORRHAGIA.

*Falk* (*Centralblatt für Gynekologie*, No. 8, 1891.) has found that hydrastin is a heart poison, while hydrastinin is not. The latter has the advantage over hydrastin of producing considerable and regular vascular contraction. This conclusion was based upon the results obtained from treating twenty-eight cases of metrorrhagia from hyperplastic endometritis, congestive dysmenorrhœa and metrorrhagia accompanied by vertigo. In the former the metrorrhagia diminished. The chloride of hydrastinin, in a 10 per cent. solution in water, in doses of 5-10 cgr. (1–1½ gr.) is the preparation employed. It should be especially used before and during the time when hæmorrhage occurs.

## OBSTETRICS.

### HYPEREMESIS GRAVIDARUM, PTYALISM AND HYSTERIA.

Ahlfeld (*Centralbl. f. Gyn.*, No. 17, 1891). Kaltenbach in a recent paper has called attention to the frequency with which the hyperemesis of pregnancy occurs in hysterical patients and to the fact that the therapeutic measures which prove most successful in the treatment of hysterical manifestations have a favorable influence in the former affection. Yet he does not claim that the pernicious vomiting of pregnancy can be directly traced to hysteria. The author has met with several cases in which hysteria was the principal foundation of the uncontrollable vomiting. He regards both the hyperemesis and ptyalism of pregnancy as nothing more than an exaggeration of the reflex neurosis common in pregnancy in many women. His management of these cases is precisely the same as in hysteria uncomplicated with pregnancy. He enforces rest, forbids intercourse with friends and prescribes all mental excitement. His results he claims substantiate his doctrine.

Apropos of this question are the following remarks from the editorial columns of "Brit. Med. Journal" of May 30th, 1891:

This subject, of so deep interest to the practitioner, is at present occupying the attention of a large number of British and foreign obstetricians. Sixteen years ago there appeared in the journal the now celebrated paper by Dr. Copeman, which was read all over the globe, and gave his name to the "method" he advocated. Copeman's method simply means dilatation of the cervix with the finger. Undoubtedly it has proved of the highest service, whatever may be of the precise nature of its action. Dr Graily Hewitt, whose work on *Severe Vomiting during Pregnancy* appeared last year, traces the disorder to flexions, with inflammatory changes in the uterus. . . Other authorities refer the trouble to lesions of the cervix, and treat them with counterirritants. . . . There remains, unfortunately, the fact that in many cases nothing stops the vomiting save termination of the pregnancy. The induction of labor is not without risk; the practitioner is unwilling to resort to it when the vomiting has not lasted long, whilst later on the patient may be fatally enfeebled by constant sickness; hence the gravity of the entire question becomes self-evident. No wonder so much is written on hyperemesis graviadarum, but much more remains to be done before anything like a sound routine practice, suitable to others than hospital obstetricians of extremely specialized experience, is established to the benefit of humanity and the comfort of the practitioner.

### PREGNANCY AND HEART DISEASE.

Dr. S. Remy (*Arch. de Tocol. et de Gynéc.*, August, 1891) publishes an instructive series of cases of death late in pregnancy from heart disease. The fatal event is sometimes sudden, taking place during work, dancing, or getting up. More often it follows asystolic phenomena. In the 15 cases collected by Dr. Remy the child was extracted, either by Cæsarean section or version, seven times; three were alive; in two of these three cases, if not in the third, death of the mother had been sudden. One fœtus extracted after "some delay" (precise length of time not being noted), was not quite pulseless when born. In cases of sudden death, the chance that the child may be living when the obstetrician acts promptly is considerable. When the mother has died from slow asphyxia due to asystolism, the child has

probably expired before its parent. In a case of this kind under Dr. Remy's own observation the child, promptly delivered by version, was beginning to macerate; it had evidently been dead for two days or more. The question of hastening delivery is grave. The actual birth of the child by premature delivery, when safely ended, leaves the woman for the time better off than before labor. Unfortunately premature labor in heart disease does not always improve the patient's condition. The cardiac and secondary lesions may be too serious to permit of more than the most temporary benefit. The labor itself places the patient for the time in extreme peril of fatal asystolism. Lastly, there remains a third fact, which may not be taken into account at the beginning of the case, when the induction of labor is contemplated. In lying-in patients with heart disease, severe cardio-pulmonary complications often set in on the third or fourth day after labor. Altogether it would appear best to induce abortion very early when cardiac disease, with grave complications, is present in a pregnant woman. Obstetricians may hesitate to take such a step, as they may wish to extract a viable child, and, as this involves some interval of time, the cardia symptoms may undergo some amelioration, or in some cases the child may die and be readily extracted. Hence it is hard to lay down a general rule; much must depend on the gravity of each individual case.—*Brit. Med. Jour.*

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### PREGNANCY AT THE AGE OF FIFTY-NINE.

Dr. E. Derasse (*Gazette Médicale de Liege*, October 1st, 1891) saw in his consulting room in August, 1889, a lady with a swelling of the abdomen. She was 59 years of age, and had been a widow for twenty years. The tumor was taken, by one of her medical attendants, for a uterine fibroid, and by another for a cyst. Arrangement had even been made for an operation. Dr. Derasse, on examining the tumor, which was uniform with the uterus, noticed a sensation as though something was moving inside it. On auscultation fœtal heart sounds could be heard; *ballotement* was also clear. The breasts were already well developed and heavy. After careful investigation of the case it transpired that the elderly patient had a young lover. On December 21st, 1889, she was delivered of a fine boy. She was then aged 59 years and 5 months, Dr. Derasse having succeeded in obtaining her birth certificate. She suckled her child well, and weaned it upon her sixtieth birthday. She stated that she had ceased to menstruate at 50 and she had a married daughter 40 years old. Dr. Derasse refers to the *Dictionnaire Encyclopédique* where several cases are recorded where mothers suckled their children at the age of 60, or even later.—*Brit. Med. Jour.*

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## PÆDIATRICS.

### THE FREQUENCY OF INFANTILE CONVULSIONS.

Dr. G. L. Walton has found that out of 1,000 children, taken consecutively at random from all classes of society, 11.1 per cent. have been found to have a history of infantile convulsions. Among epileptics whose epilepsy did not begin in infancy, seven per cent. had infantile convulsions.

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### GONORRHŒAL STOMATITIS IN AN INFANT.

Professor Dohrn describes in the *Medicinische-chirurgische Rundschau* the case of a child, eight days old, which was brought to his clinic suffering with swollen jaws. A further examination showed the back of the infant's tongue and the roof of its mouth to be eroded and covered with a grayish-yellow exudation. An acute stage of purulent conjunctivitis being present, the mother was questioned as to the possibility of gonorrhœal infection, and her answers confirmed the suspicion of this being the source of the trouble. To be positive, however, a small portion of the diseased mucous membrane of the mouth was excised and submitted for microscopical examination, and numbers of gonococci were found. It was supposed that infection took place upon the abraded mucous membrane in the child's mouth, the mechanical injury having possibly been inflicted by the accoucheur.

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### ANTIPYRETICS IN CHILDHOOD.

R. Demme (*Jahr. f. Kinderhlkde*, Bd. xxxiii, H. 1 and 2) gives the results of experience with various antipyretics in the Jenner's Hospital in Bern. They were only given at all in cases in which the temperature exceeded 103° F. for several days; in milder cases cold applications or cold baths were employed (two baths daily at 77° to 82° F. for five or ten minutes). In articular rheumatism he gave sodic salicylate, or, if there was a tendency to vomiting and

diarrhœa, salol. Doses of salicylate, daily, 2 to 4 years, 7 to 15 grains; 5 to 10 years, 15 to 30 grains; 11 to 15 years, 37 to 45 grains—of salol, thrice daily, 2 to 4 years, 4 to 5 grains; 5 to 10 years, 8 to 12 grains; 11 to 15 years, 12 to 15 grains. In typhoid fever thallin sulf. was given every two hours; to a child 3 to 4 years old, ½ grain; 5 to 10 years, ½ grain; 11 to 15 years, ½ grain to ¾ grain. In broncho-pneumonia with very high temperature (105° to 106°) he gives during the early stage hourly doses of antipin for two or three doses. Dose, 2 to 4 years, gr. iss to gr. iij; 5 to 10 years, gr. vij to xij; 11 to 15 years, gr. xij. to xv; larger doses are unnecessary, and may be dangerous. In the latter stage of broncho-pneumonia with hectic type of fever, quinine is superior to every other antipyretic. Doses, 2 to 4 years, gr. iij to vj; 5 to 10 years, gr. vij to viij; 11 to 15 years, gr. xij to xv. Antifebrin was found particularly useful in the high temperature of phthisis; like antipyrin, it sometimes caused a measly eruption. Doses, 2 to 4 years, gr. ½ to j; 5 to 10 years, gr. iss to gr. iij; 11 to 15 years, gr. iij to gr. ivss, once, twice, or thrice a day. Acetphenetidin was found a very satisfactory remedy, but had the disadvantage of causing sometimes copious sweats and frequently a measly eruption and cyanosis; it was best given in single large doses, 2 to 4 years, gr. iss to gr. iij; 5 to 10 years, gr. iij to vij; and 11 to 15 years, from gr. vij. A new remedy tested by Professor Demme was carbonyl-orthoamidphenol, or more shortly, oxycarbonil, an isomer of antifebrin which is excreted as oxycarbonil. As an antipyretic, it had to be given in larger doses than antifebrin, and its action was of very short duration, the temperature quickly rising again to the point at which it was before. Demme states that by repeating the dose every two hours, the temperature in typhoid may be kept down to 100° to 102° F.—*Brit. Med. Jour.*

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### TREATMENT OF DIPHTHERIA BY IRRIGATION OF SALICYLIC ACID.

In the *Bulletin Général de Thérapeutique* for September 15th, 1891, Dr. Parisot of Voyes publishes a paper in which he highly recommends irrigation of salicylic acid as a treatment for diphtheria. The former mortality of his cases was large (10 out of every 14); in a recent epidemic, when the new treatment was adopted, he had only five fatal cases out of every twenty-four, certainly a very satisfactory proportion for such a fatal disease. The formula which Dr. Parisot employs is as follows: Salicylic acid, one gramme water, 980 grammes; alcohol (90 per cent.), 20 grammes. The salicylic acid is dissolved in the alcohol, and the water added. The apparatus for irrigation is a fountain syringe, with the reservoir made of tin. This is hung against the wall over the patient. The rubber tubing, which is connected to a projecting nozzle at the lower part of the reservoir, ends in a small glass tube drawn out to a point. A spring catch on the tube controls the current of liquid. When the apparatus is filled with the solution the head of the child is held by an assistant, the tongue depressed, and the jet of fluid directed against the pharynx with sufficient force to detach and remove the false membranes. Several applications may be necessary to effect this, and if the membranes are not loose a little time must be allowed to elapse until this is the case. As regards the position of the head, Dr. Parisot recommends that this should be forward and a little downward. When the child is feeble, it should be supported upon the arm of the nurse with its face turned towards the floor, so as to prevent the liquid flowing back and being swallowed in large quantities. The amount of fluid used on each occasion must be learnt by experience. As a rule, three or four ounces each time is sufficient, and this should be practiced as frequently as possible. Dr. Parisot considers that salicylic acid has a destructive action upon diphtheritic formation. He showed by experiment that in distilled water the membrane simply became sodden and gradually disintegrated, this taking place very slowly, whilst in solutions of salicylic acid the membrane was rapidly dissolved; at the end of a few minutes only the meshes of network in which the cells had been supported were visible. The stronger the solution of salicylic acid the quicker and more complete was the destruction of the tissue. Dr. Parisot has further noted that when the diphtheritic membrane has been once removed by means of salicylic acid its reproduction was considerably slower and more imperfect, and therefore concludes that the acid has a favorable action upon the mucous membrane, which is rendered unsuitable for the growth of the pathogenic organism and the reproduction of the diphtheritic patches. —*Lancet.*

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An hour-glass is made smallest in the middle to show the waist of time.

## HYGIENE.

### A POISONOUS THIMBLE.

Among the numberless causes of blood-poisoning through the skin, one which was lately recorded is worth noting on account of its evident simplicity and the ease of its prevention. In the case referred to the sufferer was a seamstress, and the mischief resulted from her using a dirty metal thimble marked with verdigris, a little of which appears to have entered a scratch on the thimble finger. We can well believe that this accident was not the first of its kind. Verdigris, it is true, is a mere metallic irritant, and not comparable in virulence to most living germs of disease. It is quite enough, notwithstanding, to excite local inflammation, which friction, contact with dyed cloth material, or the entrance of dirt in any form would quickly convert into a dangerous and general disorder. There is really no excuse for women who trust their fingers in these cheap and worse than useless articles. Steel thimbles are much safer and cost very little. Another variety also in common use is enamelled within, and is, if possible, even freer from objection. Let us not forget to add a caution that cuts or scratches on the hand should never be neglected by sewing women so long as dyes continue to be used in cloth manufacture.—*Lancet.*

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### TUBERCLE BACILLI IN THE AQUEOUS HUMOR OF CATTLE.

M. Mandereau, of Grenoble, having recently stated (see *British Medical Journal*, July 4th, 1891, p. 24) that tubercle bacilli could be seen in the aqueous humor of bovine animals suffering from tuberculosis before any other visible sign of the disease was present, MM. Leclinche and Greffier (*Sem Méd.*, July 1st, 1891) made a series of observations which, according to them, show the statement to be erroneous. They examined the eyes of twenty tuberculous oxen, and in no single instance could the tubercle bacillus be found in the aqueous humor, nor did the intra-peritoneal inoculation of that fluid in guinea-pigs in any case induce tuberculosis in the these animals.—*Brit. Med. Jour.*

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If you are inclined to wonder at the number of maladies in the world, you should count the cooks.

## MEDICAL CHEMISTRY.

### HOW TO TEST DRINKING WATER FOR IMPURITIES.

Dr. Frederick J. Wulling, says in the *Pharmaceutical Era*: Sometimes the pharmacist is called upon, especially if his sign reads "chemist and druggist," to ascertain whether a sample of water is fit for drinking and domestic purposes or unfit for that end. It isn't a very difficult matter to apply a few tests for the simple determination of the figures or otherwise of a sample in question. A complete examination of the character of a sample of water is a very difficult problem and should be referred to a skilled chemist. The substances to be looked for primarily are organic matter, albumenoid matter, ammonia, nitrates and nitrites.

The nitrogen compounds are usually more abundant if animal matter is present; they of all other abnormal constituents render water the most unwholesome. Their presence, and of ammonia and of albumenoid substances, do not necessarily render water unfit for domestic purposes, but water containing them or either one usually becomes the breeding place of the germs of contagious diseases if they are around.

1. For organic matter, put a little of the sample into a beaker, add 2 or 3 drops of dilute sulphuric acid and color distinctly with a solution of permanganate of potassium. If much organic matter is present the color of the permanganate becomes discharged almost immediately; if less or very little, it takes longer to decolorize. If the color has not changed in 25 or 30 minutes it is safe to assume that organic matter was not present. This is a tolerably reliable test.

2. For nitrites, a little sulphuric acid added to the water forms nitrous acid if nitrites are present, which is easily detected by its power of liberating iodine from iodide of potassium. A little starch paste is mixed with a small quantity of a solution of potassium iodide, and the mixture added to the suspected water containing the sulphuric acid. If nitrites were present the nitrous acid formed liberates the iodine from the iodide, which turns blue with starch. This indirect method is a ready means for detecting the nitrites if present in not too small a quantity.

3. Nitrates are detected by converting into nitric acid, which turns morphia red. A portion of the water is evaporated to dryness, the residue treated with a drop of strong sulphuric acid (which makes nitric

acid of the nitrate) and a portion of morphine added. If nitrate was present the morphine gives red color.

4. For ammonia, Nessler's reagent is by far the best test. It may be made by dissolving 18 grains of oxide of potassium in a little water, adding solution of mercuric chloride until the red iodide of mercury first formed redissolves upon agitation. To this is added a solution of 50 grains of caustic potassa and distilled water to make 8 ounces.

This reagent will detect 0.00375 of a grain in a pint of water by giving a yellow color. A reddish color or precipitate forms with larger quantities of ammonia.

5. Albumenoid matter requires a more elaborated proceeding for its detection. If all of the above were found it is hardly necessary to go to the trouble of looking for albumenoids; the water would be unwholesome even if they were not present. If it is desired to test for them, nevertheless, Chapman and Waukly's test is the simplest to employ. If the water was found to contain ammonia, the latter must first be removed, as must also any urea that may be present. This is best done by distilling the water until it gives no reaction with Messler's reagent. Then add a strong solution of caustic potash and potassium permanganate and examine again for ammonia.

This test depends upon the fact that caustic potash and permanganate of potash cause animal matter while still in an albuminoid condition to unite with hydrogen to form ammonia.

It must not be understood that the tests just given are the only ones; on the contrary there are a vast number, all more or less useful, for the determination of the quality of a drinking water, but they are not all as practical and easily applied.

## Clippings and News Items.

### AN ARMY MEDICAL BOARD.

Will be in session in Chicago, Illinois, during February, 1892, for the examination of candidate for appointment in the Medical Corps of the United States Army, to fill existing vacancies.

Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before January 15, 1892, for the necessary invitation, stating the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from whence they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal knowledge, from at least two physicians of repute, as to professional standing, character, and moral habits. The candidate must be between 21 and 28 years of age, and a graduate from a Regular Medical College, as evidence of which, his Diploma must be submitted to the Board.

Further information regarding the examinations may be obtained by addressing the Surgeon General U. S. Army, Washington, D. C.

### AMERICANS IN THE RIVIERA.

Dr. Wendt has been commissioned to visit the Riviera and the health resorts of the south of France in order to study and to report on the healthy conditions and the sanitary (or insanitary) arrangements, municipal and domestic, of the towns and hotels at such places as Cannes, Nice, Pau, Hyéres, Mentone, Monaco, San Remo, Alassio, Bordighera, Florence and Naples. He will find much to exercise his industry and acumen—much to blame, something to encourage, and many causes for warning to his countrymen. American visitors to the Continent are particularly liable to typhoid—of which the frequently recurring and sad examples are probably the main cause of this journalistic tour of inspection. Part of this special liability probably arises from their habit of drinking iced water. So long as, following the advice of Dr. Herman Weber, they confine themselves to natural mineral waters of recognized purity, they are safe. But these are not always at hand, and all do not yet understand that icing or aërating polluted water detracts nothing from its risks, and that even ice itself made from impure water is a source of danger. Where only "local drinking water" is to be had in the Riviera or anywhere on the Continent of Europe, it should always be first boiled and then filtered, as Dr. Gowers advises.—*British Medical Journal*, of Dec. 5th, 1891.

Dr. B. W. Richardson describes (*Asclepiad*, XXXI.) some old experiments in which he caused local anæsthesia by applying the positive pole of an electric battery over some narcotic. In many cases complete local anæsthesia was obtained; whilst the check experiments of applying the solutions and the current separately were followed by no anæsthesia.